Division of Family Support

OPERATION MANUAL
Volume IVB

OMTL- 532

MAGI Medicaid

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[MAGI MEDICAID OVERVIEW

MS 1000 (1)

Applications for Modified Adjusted Gross Income (MAGI) Medicaid and Kentucky Children's Health Insurance Program (KCHIP) are accepted on the benefind Self-Service Portal (SSP) and Worker Portal. Applications for individuals who apply on the Federally Facilitated Marketplace (FFM) and are determined to be potentially eligible for Medicaid are transferred to Worker Portal through account transfer. Individuals applying for Medicaid on the SSP or Worker Portal who are determined to be over the income limits for Medicaid will have their information transferred to the FFM as potentially eligible for Qualified Health Plan (QHP) and Advanced Premium Tax Credit (APTC).]

A. Medicaid is extended to adults and children who meet certain technical and financial eligibility criteria. The Department for Medicaid Services (DMS) is the state agency with designated responsibility for the administration of Medicaid in compliance with Title XIX of the Social Security Act.

   MAGI rules will be used to determine eligibility in four categories:

   1. Children under age 19;

   2. Pregnant Women;

   3. Parents and Caretaker Relatives; and

   4. Low Income Adults age 19 through 64.

B. Individuals must meet technical (non-financial) and financial eligibility requirements to qualify for MAGI Medicaid. Both Federal and State data sources will be used to help determine if the individual(s) meets these requirements. MAGI household composition is based on the tax filing status of the individual(s) applying for benefits.

C. [A deduction of 5% of the appropriate federal poverty level (FPL) is applied to the total income for the family size for Medicaid determination when applicable.]

D. Resources are not considered in the eligibility determination of MAGI Medicaid.

E. Applicants will be required to provide verification of citizenship, income, and incarceration if initial client stated information does not match with Federal or State data sources. Self-attestation or client statement is acceptable for residency, pregnancy, household composition, and relationship unless conflicting documentation is received.

F. [The 5 year ban to receive Medicaid for qualified aliens no longer applies to children under the age of 19 who meet qualified alien criteria or are lawfully present.

G. MAGI Medicaid eligibility determinations will pend for 30 days to provide required verification at initial application and recertification.]

H. Applications can be processed for individuals who are potentially eligible in MAGI Medicaid categories, including the Adult category, even though they have pending SSI applications.

MS 1050 MAGI MEDICAID DEFINITIONS (1)

Terms used in modified adjusted gross income (MAGI) Medicaid:

ACCOUNT TRANSFER: The process by which an individual's information is transferred from the Federally Facilitated Marketplace (FFM) to Worker Portal in order for Medicaid eligibility to be determined or by which an individual's information is transferred from Worker Portal to the FFM in order for Advanced Premium Tax Credit (APTC) and/or Qualified Health Plan (QHP) eligibility to be determined.

ACTIVE RENEWAL: Occurs when an individual does not authorize on-going data checks with trusted data sources, information received back from the trusted data sources is not reasonably compatible, or there is a change in eligibility. This requires action on the part of the recipient in order for the renewal to be completed.

ACTUARIAL VALUE: The average share of medical spending that is paid by a health plan as opposed to being paid out-of-pocket by the consumer.

[ADVANCED PREMIUM TAX CREDIT (APTC): A tax credit to lower the monthly premium of health plans offered through the FFM for families earning less than 400% of the Federal Poverty Level (FPL). The FFM determines eligibility for APTC.

ASSISTER: Certified individuals that assist with applications and enrollments for APTC and Medicaid. They inform individuals requiring QHPs of the need to apply on HealthCare.gov, provide assistance with coverage options, and provide education and outreach.

BENEFIND: The website where an individual, authorized representative (AR) or Assister can apply for benefits such as KTAP, SNAP, and Medicaid.]

BENEFIT YEAR: The calendar year for which a health plan provides coverage for health benefits.

CARETAKER RELATIVE: Any individual that provides care to a child in the household. This individual is related by blood, adoption, or marriage to the dependent child. This includes step-parents. The child resides with the caretaker relative and they assume primary responsibility for the child's care.

CERTIFIED APPLICATION COUNSELORS (CAC): A certified individual or group that provides education and enrollment assistance.

CHILD: An individual who is under the age of nineteen (19). They are not self-supporting or participating in any of the United States Armed Forces.

DEEMED ELIGIBLE NEWBORN: A baby whose mother received Kentucky Medicaid during the month of the baby's birth. He or she is guaranteed Medicaid from the birth month through the 12$^{th}$ month without regard to technical or financial eligibility factors other than residency.

DEEMED ELIGIBLE PREGNANT WOMAN: A woman determined eligible for Medicaid

due to pregnancy is entitled to continued coverage through the post-partum period. This does not apply to individuals who move out of state during this period.

DEPARTMENT OF HOMELAND SECURITY (DHS): The Federal agency responsible for the determination of citizenship or alien status.

[ELIGIBILITY DETERMINATION GROUP (EDG): A method of forming groups for each individual to determine eligibility for Medicaid. This grouping establishes which individuals are considered in the household size and identifies what income will be considered in determining eligibility.]

EMPLOYER SPONSORED INSURANCE (ESI): Insurance offered through employers.

FEDERAL HUB: A collection of trusted data sources that will be matched against client stated information in order to verify certain eligibility factors. Some of the trusted data sources include, but are not limited to: Social Security Administration (SSA), Department of Homeland Security (DHS) and Internal Revenue Service (IRS).

[FEDERALLY FACILITATED MARKETPLACE (FFM) – An eligibility and enrollment service for APTC and QHPs that is operated by the Federal Government.]

GROSS INCOME: The total sum of earned or unearned income prior to any deductions.

INCOME: Earned or unearned money received from sources including, but not limited to: wages; statutory benefits, such as RSDI and UIB; rental property; business operations, etc.

KENTUCKY CHILDREN'S HEALTH INSURANCE PROGRAM (KCHIP): Program of Medicaid coverage for uninsured children under age 19, in compliance with Title XXI of the Social Security Act.

KYHEALTH CHOICES CARD: The permanent plastic card issued to all Medicaid and KCHIP recipients used as an identification card. The Medicaid ID number found on the card is used by providers to verify current eligibility.

LEGAL GUARDIAN: An individual appointed through the State district courts to be in charge of the affairs and finances of an individual.

LOW INCOME ADULT CATEGORY: Individuals age 19 through 64 who are not pregnant, entitled to Medicare A or B, or enrolled in another Medicaid eligibility group. The total countable income is less than or equal to 133% of FPL.

MEDICAID (MA): Medical benefits provided to eligible individuals in compliance with Title XIX of the Social Security Act.

MANAGED CARE ORGANIZATION (MCO): Organizations that link Medicaid recipients with participating physicians who are responsible for coordinating and providing their primary medical care.

MINIMUM ESSENTIAL COVERAGE (MEC): Coverage that meets the individual responsibility requirement under the Affordable Care Act. This includes individual

market policies, job-based coverage, Medicare, Medicaid, KCHIP, TRICARE and certain other coverage types.

[MIXED HOUSEHOLD – A household in which at least one individual receives Medicaid or KCHIP in Worker Portal, and at least one individual receives APTC/QHP on the FFM.]

MODIFIED ADJUSTED GROSS INCOME (MAGI): Taxable income minus specific deductions, for example, alimony, student loan interest, and educator expenses.

NON-MAGI: Individuals exempt from MAGI based eligibility determinations.

NON-RECURRING LUMP SUM INCOME: Income received at one time and not expected to continue.

NON-TAX FILER: An individual who does not intend to file taxes for the current benefit year. They may or may not be claimed as a tax dependent by another individual.

PARENT: The natural, adoptive, or step-parent of a child.

PASSIVE RENEWAL: Occurs when an individual has authorized on-going data checks from trusted data sources. If the information returned matches the data sources or is within reasonable compatibility, the case is updated and recertified with no worker or recipient action required.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA): Federal statute signed into law in March 2010. It is primarily aimed at reducing overall health care costs and decreasing the number of uninsured Americans.

[QUALIFIED HEALTH PLAN (QHP): A commercial insurance plan offered to Kentucky residents through the FFM.]

REASONABLY COMPATIBLE: The allowable difference between an individual's stated amount of income and verification provided by the Federal HUB. The current standard for reasonably compatible is 10%.

RETIREMENT, SURVIVORS, DISABILITY INSURANCE (RSDI): Social Security benefits payable under Title II of the Social Security Act.

SELF-ATTESTATION: Client statement.

SELF-EMPLOYMENT: Earned income for which NO taxes are withheld before it is received by the individual.

STATUTORY BENEFIT PAYEE: The payee for the applicant/recipient's SSI or statutory benefits, such as RSDI, VA, or Railroad Retirement.

SUPPLEMENTAL SECURITY INCOME (SSI): Federal money payments to aged, blind, or disabled individuals under Title XVI of the Social Security Act.

TAX DEPENDENT: An individual for which a tax filer claims a personal exemption

deduction during the taxable year.

TAX FILER: An individual who has filed or intends to file an income tax return for the current benefit year and cannot be claimed as a dependent by another individual.

[WORKER PORTAL: Eligibility determinations for KTAP, Kinship Care, Medicaid, and SNAP are completed on the Worker Portal by DCBS staff.]

MS 1070 CATEGORIES OF ASSISTANCE (1)

[Modified Adjusted Gross Income (MAGI) Medicaid eligibility is divided into four categories: Children under age 19, Pregnant Women, Parents and Caretaker Relatives, and Low Income Adults ages 19 thru 64. The four categories are listed below with a brief description and the type of assistance (TOA):

A. Children under age 19: This category includes Medicaid and Kentucky Children's Health Insurance Program (KCHIP) individuals. Countable income is compared to the current Federal Poverty Level (FPL):

1. Medicaid includes children age 19 and under who meet school attendance requirements. Accept client statement for school attendance.

| TOA | Category | FPL | FPL with 5% Increase |
|---|---|---|---|
| CHL4 | Medicaid Children age 6-18 (P1) | 109% | N/A |
| CHL2 | Medicaid Children ages 1-5 (P2) | 142% | 147% |
| CHL1 | Medicaid Children < age 1 (P3) | 195% | 200% |
| CHL3 | Medicaid Children age 6 – 19 (P5) | 142% | 147% |
| TP45 | Deemed Eligible Newborns | N/A | N/A |

2. KCHIP includes children up to their 19th birthday who do not have health insurance. KCHIP has no school attendance requirements.

| TOA | Category | FPL | FPL with 5% Increase |
|---|---|---|---|
| CHEX | KCHIP Children age 0 – 19 (P6) | 159% | N/A |
| CHIP | KCHIP III Children < age 19 (P7) | 213% | 218% |

B. Pregnant Women: This category includes individuals who are pregnant or in their postpartum period. The TOA on Worker Portal is PREG. These individuals have income at or below 200% FPL.

1. Pregnant women receiving Medicare can be dually eligible for Qualified Medicare Beneficiary (QMB) or Specified Low-income Medicare Beneficiary (SLMB) in the PREG TOA.

2. Pregnant women are deemed eligible through the postpartum period. A woman must be eligible in the application month to be deemed eligible in the PREG TOA.

a. Eligibility in a retro month does not meet the criteria for deemed eligibility if the woman is not eligible in the application month.
b. Deemed eligibility does not apply to women incorrectly determined eligible at application.

3. Children under the age of 19 who become pregnant will have eligibility issued in the PREG TOA.

C. Parents and Caretaker Relatives: This group includes individuals who are a parent (including stepparents) or a caretaker relative of a dependent child in the home. The TOA on Worker Portal is PACA. The income for individuals in this category is compared to the appropriate MA scale for their household size. In addition:

1. A caretaker relative is an individual, other than the parent or stepparent, who provides a home for the child and is related by birth or marriage. Workers must check the Caretaker Relative indicator on the Relationship Screen to indicate that an individual is the caretaker relative of the child.

2. If a parent or stepparent resides in the home, it is not appropriate to designate another individual as a caretaker relative.

   For example, Mom, grandmother, and child reside in the same home. Grandmother should not be designated as the caretaker relative.

3. Individuals receiving Medicare can be dually eligible for QMB or SLMB in the PACA TOA.

D. Low Income Adults ages 19 through 64: The TOA on Worker Portal is ADLT. Individuals in this category have income at or below 138% FPL.

1. Worker Portal will explore eligibility in all other Medicaid categories prior to issuing eligibility in the ADLT TOA. For example, a low-income woman who is pregnant will receive in the PREG TOA.

2. Individuals who are eligible for or enrolled in Medicare are not eligible in the ADLT TOA. This includes individuals who decline Medicare enrollment.

3. Individuals with health insurance other than Medicare may receive in the ADLT TOA.]

MS 1200 RIGHT TO APPLY (1)

[All individuals have the right to make an application and receive a decision on their eligibility for Medicaid. Individuals may make an application for any program offered by the agency in any county office, regardless of the county of residence. Applications may be made by the individual, spouse, parent or caretaker relative of a minor child, statutory benefit payee, guardian, power of attorney (POA), or authorized representative (AR).

A. Applicants have 30 days to provide mandatory verification, however if they do not provide the requested verification and the case denies, there is an additional 30 day grace period from which the application may be reactivated on Worker Portal without a new application being initiated by the applicant. This is referred to as a 30/60 reapplication:

1. The individual does not need to reapply; and

2. The grace period is either 30 days from the date of denial or 60 days from date of application. The reactivation date is the date all requested verification was received.

For example: An applicant applies on May 1, 2018 and income fails to match against trusted data sources. A Request for Information (RFI) is issued requesting income verification by May 30, 2018. The applicant does not return the information timely and the application denies. On June 15th, the applicant returns the requested income verification.

The denied application is reactivated on Worker Portal using the 6/15/18 date. Workers must indicate in case notes that the case is a 30/60 reapplication.

B. Individuals may make an application by any of the following methods:

1. Calling the Contact Center at 1-855-459-6328;

2. Calling Department for Community Based Services (DCBS) at 1-855-306-8959;

3. Mailing a completed paper application to DCBS at:

P.O. Box 2104
Frankfort, KY 40601

4. Faxing a completed paper application to 1-502-573-2005;

5. Submitting an application at www.benefind.ky.gov; or

6. In person at any DCBS office.]

C. The application is signed by the applicant, the applicant's statutory benefit or SSI payee, legal guardian, power of attorney (POA), or authorized representative (AR). If the application is signed by a mark (X), another

person, either related or unrelated, must sign the application as a witness. Use the applicant's name for the case name even if the application is signed by someone other than the applicant.

D. If the individual is physically or mentally disabled or elderly, provide reasonable accommodation to any special needs the individual may have no matter where/how the interview is conducted. Accommodation to special needs may include, but is not limited to:

1. Interpreter services for hearing impaired individuals. Refer to Volume I, MS 0220

2. Additional space for the interview to accommodate an individual in a wheelchair;

3. Scheduling appointments when special transportation services are available; or

4. Making a home visit.

E. If the individual is non-English speaking, obtain interpreter services. Refer to Volume I, MS 0230.

[F. Retroactive Medicaid is ONLY appropriate for individuals eligible for Medicaid as a child, pregnant woman, or former foster care child, who have incurred medical expenses in the three months prior to the application date.]

MS 1212 INTERVIEW PROCESS (1)

[Individuals applying for Modified Adjusted Gross Income (MAGI) Medicaid or Kentucky Children's Health Insurance Program (KCHIP) through the Department for Community Based Services (DCBS) must be interviewed. Interviews may be conducted in-person, by phone, or home visit.

Interviews are not required for MAGI Medicaid applications made via the benefind Self Service Portal (SSP).

The following procedures must be followed when conducting an interview:

A. Before the interview:

1. Review all previous case information thoroughly; and

2. Inform the individual that if determined to be over the income limit for MAGI Medicaid, Worker Portal will complete an account transfer to the Federally Facilitated Marketplace (FFM) for an eligibility determination.

B. During the interview:

1. Inform the individual of their rights and responsibilities;

2. If the individual is applying for MAGI Medicaid or KCHIP review form MA-2, Medicaid Penalty Warning and obtain client signature;

3. Advise the individual that changes must be reported within 30 days;

4. Advise the individual of the right to appeal any adverse action; and

5. If the head of household is present at the interview and is age 18 or older or will be age 18 before the next election, explain the voter registration process and complete the voter registration questions on Worker Portal.

C. Inform the individual of the Medicaid eligibility processes:

1. Explain that tax filing status is used in determining eligibility, therefore it is essential that the individual gives accurate information regarding their status;

2. Explain that if income or incarceration verification is required, an individual will have 30 days to return the requested information, but a determination of eligibility will not be made until documentation is received;

3. Explain that if verification of citizenship is the only documentation requested, initial eligibility will be determined and if approved the individual has 90 days to return the requested information. If verification of citizenship is not returned at the end of 90 days, Medicaid eligibility will end the next administratively feasible month;

4. Advise the individual that their managed care organization (MCO) or Medicaid Member Services answers all questions regarding coverage and/or billing. The MCO's phone number is listed on their member card and the phone number for Medicaid Member Services is 1-800-635-2570;

5. Ask if any members of the Medicaid household have unpaid medical expenses in the three months prior to application. Explain that retroactive Medicaid coverage can only be approved for individuals eligible for Medicaid as a pregnant woman, child, or Former Foster Care Youth. Refer to Volume IVB, MS 1600 for more information regarding retroactive Medicaid;

6. Explain Managed Care. For more information on Managed Care refer to Volume IVB, MS 1900; and

7. Explain third party liability (TPL) and that Medicaid is the payer of last resort. Any other health or hospital insurance is billed before Medicaid. Enter all health insurance information on Worker Portal.

D. Explain all Kentucky HEALTH requirements, including:

1. Cost share requirements and conditional eligibility;

2. PATH and community engagement requirements; and

3. The My Rewards Account.

E. Inform the individual if found to be ineligible for Medicaid they will have their information transferred to the FFM for an eligibility determination.

F. If trusted data sources match within reasonable compatibility, dispose the case and Worker Portal will process the application. If client information fails the Federal Hub and the applicant has the information available at the time of the interview, enter the verification and dispose the case. If the client does not have the verification with them at the time of the interview, ensure that Worker Portal issues a Request for Information (RFI).

G. Enter all required Case Notes, plus comment on any unusual circumstances or documentation.

H. Answer all of the individual's questions.

I. Scan into the Electronic Case File (ECF) all documents pertaining to eligibility and the signed application.

J. If additional information is required from the Medical Support and Benefits Branch (MSBB), send the request to the regional Program Specialist immediately to prevent delays in processing the case.]

MS 1213 WHO SIGNS THE APPLICATION (1)

The individual(s) allowed to sign the application may vary depending on specific program requirements. Below are the policy specifications regarding who can sign the application:

A. [Applications for Medicaid may be signed by one of the following:]

1. The applicant;

2. The applicant's spouse;

3. The statutory benefit payee, legal guardian, power of attorney (POA), or the authorized representative (AR); or

4. The parent or caretaker relative of a child.

B. If an individual or their representative signs an application by making a mark (X), the mark must be witnessed by one person, related or unrelated to the individual, who can write.

MS 1220 ENTITLED BENEFITS (1)

[Modified Adjusted Gross Income (MAGI) Medicaid eligible individuals are required to apply for any benefits to which they may be entitled. These benefits include, but are not limited to, Veteran's compensation and/or pension, Black Lung, RSDI, Railroad Retirement, annuities, pensions, IRA disbursements, retirement and Unemployment Insurance Benefits.

A. Self-attestation is acceptable for the application of benefits.

B. For MAGI Medicaid eligibility purposes, the Department for Medicaid Services (DMS) considers IRA funds in the same manner as entitled benefits. Individuals are required to withdraw IRA funds if the funds are available.

At age 59 ½, a withdrawal is required, but there is no minimum amount. At 70 ½, the required minimum disbursement (RMD) must be withdrawn annually. Minimum amounts are determined by the financial institution. Failure to comply with this requirement results in ineligibility for Medicaid.

C. KTAP or State Supplementation payments, SSI benefits, VA Aid and Attendance Allowance or cash benefits of a similar nature are NOT considered entitled benefits.]

MS 1230* SSI APPLICATIONS (1)

Accept and process an application for Modified Adjusted Gross Income (MAGI) MA for an individual with a pending SSI application. This also includes individuals eligible in the MAGI Low Income Adult category.

Spot check each month to verify approval or denial of SSI. Take appropriate action if SSI is approved.

If the individual applies for MA in any category within 60 days of an SSI denial based on non-disability and the individual would have been MA eligible in any of the MAGI categories had the individual applied earlier, use the SSI application date as the MA application date.

If an SSI application is denied for reasons other than non-disability, and the individual applies for MA within 60 days of the SSI denial, use the SSI denial date as the MA application date.

MS 1240* APPLICATIONS FOR THE DECEASED (1)

Applications for the deceased are accepted but may require additional information before they can be processed. All MAGI Medicaid applications are processed on kynect. Deceased individuals who fall into the Non-MAGI categories must be processed on KAMES.

In addition the following applies:

A. Medical bills must have been incurred during the three months prior to application or during the application month.

B. The individual must have been financially and technically eligible at the time services were rendered.

MS 1250 CASE FILE CONTENT (1)

[All case records represent a continuing documentation of eligibility for Medicaid and must contain sufficient material to substantiate validity of all authorized assistance.

The Electronic Case Files (ECF) for Medicaid should contain the following material as appropriate:

A. Applications;

B. Documentation and verification of technical and financial eligibility;

C. All appropriate forms;

D. Hearing information;

1. Notice of scheduled hearing;

2. Recommended Order;

3. Final Order; and

4. Appeal Board Order.

E. Information regarding potential fraud referrals, as appropriate; and

F. Any additional pertinent information or verification.]

[Individuals are required to report changes in circumstances within 30 days. Individuals may report changes in person, in writing, via phone, or through the benefind Self Service Portal (SSP).

A. A change in circumstances is defined as a change in income, household composition, or residency which may affect ongoing eligibility for Medicaid.

This includes:

1. Beginning or ending employment;

2. Increase or decrease in the number of work hours;

3. Pay rate change;

4. Increase or decrease in unearned income;

5. Change in farming/self-employment activities;

6. Change in household composition; or

7. Change of residency, including moving out of state.

B. Do not consider normal fluctuations in income as a change in circumstances. This includes:

1. A change in work hours which will not exceed 30 days;

2. A 5th or periodic paycheck; or

3. Holidays, vacation days or sick leave not to exceed 30 days.

C. When a change is entered on Worker Portal, the system will attempt to verify the change in circumstances via Federal and State Data Sources. If Worker Portal is unable to verify the reported change, a Request for Information (RFI) is issued. This includes changes reported by the individual via the benefind SSP.

D. When adding a new member to a case, the effective date is the first day of the month in which the change was reported. NOTE: The effective date for deemed eligible newborns is always effective from the child's date of birth.

Each member of the benefit group, other than a deemed eligible newborn, is required to furnish a Social Security Number (SSN) or apply for an SSN as a technical eligibility requirement. Members who are not enumerated, but are cooperating with the enumeration process should be included if they are requesting assistance. If the individual returns verification for the new member, but fails to enumerate that member or indicate they are cooperating with the enumeration process, the new member is technically

excluded from the case. Do NOT require an individual who will not be a member of the benefit group to provide an SSN or apply for an SSN.

E. Any changes which affect Kentucky HEALTH eligibility. Ensure all employment start and end dates, hours worked, student status, and changes to household composition are correctly entered in Worker Portal as this may affect Kentucky HEALTH requirements for individuals in the household.

Example: Betty is a single mother currently receiving Medicaid in the PACA Type of Assistance (TOA). Since she is the primary caregiver she is exempt from Kentucky HEALTH PATH requirements. She reports that her child is no longer in the household. Betty's TOA will change to ADLT and she will have a PATH Requirement and her Medicaid plan will change from the State Plan to the Alternative Benefit Plan (ABP). Betty's premium may also increase if her change in household size changes the Federal Poverty Level (FPL) percentage for her case.]

MS 1320* STANDARDS OF PROMPTNESS (1)

The Department for Medicaid Services (DMS) sets time frames, policy and procedures. DCBS is contracted by DMS to determine eligibility for individuals using the policy and procedures set by DMS. Applicants have 30 days to provide mandatory verification. If additional time is requested to obtain mandatory verification, pend the case over 30 days.

All applications or reapplications must be acted on promptly. The case is to be processed the day all verification is returned, if possible, but no later than 5 days from the date the information is received. No more than 30 days should elapse between the application date and the approval or denial action date. If the case cannot be processed within the time standard, document in the case record the reason for the delay. A case must never pend indefinitely.

A. The 30 day time frame allows the client time to return requested information.

B. If the case cannot be processed within the time standard due to UNUSUAL CIRCUMSTANCES, document the reason for the delay. Examples of unusual circumstances include:

1. A policy clarification was requested timely and a response has not been received from MSBB (document in the case record).

   To ensure that processing time frames are met, send clarification requests to MSBB on a daily basis through your regional chain of command.

2. Information is discovered that the worker was not aware of at application. Mail a new RFI requesting the additional verification.

   If the newly discovered information was worker error, allow additional time if needed and send an RFI with a new due date. However, if the newly discovered information was due to client's failure to report, mail a new RFI with an explanation of the additional information that is needed. A new due date is not appropriate and the original due date assigned is left as is.

C. Requested documentation from a third party may take more than 30 days. If the applicant/representative can show that effort has been made to obtain the required documentation, the worker may allow a reasonable amount of time past the 30 days. This must be approved by a supervisor and the case comments are to be documented.

   If the applicant cannot show that effort was made to obtain the required documentation, allow the application to deny. Do not assume more time is needed.

## MS 1460 TIMELY NOTICE OF DECREASE/DISCONTINUANCE (1)

[If action is taken to discontinue benefits for Medicaid for any or all members in a case, the client must be notified of the proposed action 10 calendar days prior to the effective date, unless one of the exceptions to the timely notice requirement applies. This 10-day period is the timely notice period.

A. Worker Portal will send a notice when action is taken on the system. If the system issued notice has an incorrect denial/discontinuance reason for Medicaid, immediately send a manual form MA-105, Notice of Eligibility or Ineligibility, informing the client of the correct denial/discontinuance reason. Scan form MA-105 into Electronic Case Files (ECF).

B. Case changes entered on the system with a timely notice period expiring on or before the monthly adverse action date for the current month are effective the following month.

   Example: Client reports an increase in income on 10/5/16. The change is processed on 10/9/16. Form HBE-005, Health Benefits Eligibility Notice, is issued notifying the recipient(s) of the adverse action. As the change was processed PRIOR to adverse action it will be effective 11/1/15.

C. If the timely notice period does not expire in the month form HBE-005, Health Benefits Eligibility Notice, is sent, action is taken by Worker Portal the day following the expiration of the timely notice period and is effective the next administratively feasible month.

   Example: Client reports an increase in income on 10/11/16. The change is processed on 10/25/16. Form HBE-005 is issued notifying the recipient(s) of the adverse action. As the change was processed AFTER the adverse action date, it will be effective 12/1/16.

D. The following situations are EXCEPTIONS to the 10-day timely notice:

   1. Death of a recipient has been verified.

   2. Location of the recipient is unknown and mail has been returned.

   3. The recipient has moved out of state or it has been verified that assistance has been applied for or approved in another state.

   4. The recipient enters a correctional facility, is under age 65 and enters a state tuberculosis hospital, or is between age 21 and 65 and enters a mental hospital or psychiatric treatment facility.

   5. A recipient requests discontinuance by a signed statement.]

MS 1490 REASONS FOR NEGATIVE ACTION (1)

[Denials and discontinuances result from failure to meet technical and/or financial eligibility requirements for Modified Adjusted Gross Income (MAGI) Medicaid. Worker Portal generates form HBE-005, Notice of Eligibility, for any change in eligibility.

Below are the negative action reasons for MAGI Medicaid,:

A. Financial reasons:

1. Income exceeds limit;
2. Income has increased;

B. Technical reasons:

1. Already received Medicaid;
2. Individual is above the age limit of 64;
3. Child is above the age limit;
4. Ineligible for Medicaid in the Former Foster Care category;
5. Ineligible alien/citizenship;
6. Refused to cooperate with medical support enforcement (MSE);
7. Recipient deceased;
8. Individual becomes eligible for Medicare and is no longer eligible for ADLT type of assistance (TOA);
9. Child receiving KCHIP becomes insured.
10. Individual is not a resident of Kentucky;
11. Failure to provide social security number (SSN);
12. Failed or refused to cooperate with third party liability;
13. Failure to sign application;
14. Failure to provide required information during the specified time frame;
15. Pregnancy post-partum has ended.

C. Other reasons:

1. Eligibility denied as individual is neither related to nor a tax dependent of any of the members in the case;

2. Case is withdrawn for an individual;

3. Client request;

4. Unable to locate.]

MS 1500 MISREPRESENTATION AND FRAUD (1)

If a worker discovers that the recipient or responsible party withheld information or provided false information in order to receive Modified Adjusted Gross Income (MAGI) Medicaid for which they were not entitled, refer to Volume I, MS 1200-1240 for appropriate action.

If an individual reports fraud regarding MAGI Medicaid to the local office, provide the Office of Inspector General (OIG) toll-free fraud hotline telephone number 1(800) 372-2970.

If situations of suspected provider fraud or abuse are reported, send a memorandum with a summary of the situation to OIG at the address below or by email at CHFS.fraud@ky.gov. Attach a copy of any available documentation with the OIG memorandum. Scan original documentation into Electronic Case Files (ECF). Send correspondence for OIG to:

Office of Inspector General
Division of Special Investigations
275 E Main Street, 5E-D
Frankfort, KY 40621-0001

MS 1530* KYHEALTH CARD (1)

Kynect issues a KYHealth card at initial approval to all individuals eligible for ongoing Medicaid coverage. Kynect also issues a KYHealth Card to those individuals who have not received Medicaid on KAMES or SDX in the three prior months. If an individual has had an interruption in coverage on kynect or has received Medicaid on KAMES or SDX in the three prior months, a new card is not automatically issued. The individual should utilize the original KYHealth card, unless the individual no longer has the original card and requests a new one be issued.

The KYHealth card is also issued at initial approval for Spend Down eligibility periods. A new card is not issued for subsequent Spend Down approval periods unless the individual no longer has the original card and requests a new one be issued.

If the individual maintains no fixed or permanent address, and cannot provide a mailing address, the KYHealth card can be issued in care of the local DCBS office. This procedure is used only at the individual's request when no other means of delivering the KYHealth card are available.

A. If an undelivered KYHealth card is received in the local office, take the following action:

1. Send the KYHealth card to the new address, if available, and assure appropriate action is taken to correct the address; or

2. If the new address is unavailable, attempt to contact the recipient. If the recipient provides a change of address, update kynect and send the KYHealth Card to the appropriate address. If the individual cannot be located, assure appropriate action is taken to discontinue eligibility.

B. Local offices should maintain a centralized file for KYHealth Cards returned by Central Office. If an individual requests a duplicate KYHealth card, the centralized file in the local office is to be checked before issuing a new card.

C. Do not process requests for duplicate KYHealth cards on new approvals less than ten days from the case disposition except in emergency medical need situations.

D. Requests for duplicate cards for Modified Adjusted Gross Income (MAGI) Medicaid recipients are processed by Department for Community Based Services (DCBS) staff. These cards are issued by selecting MAID Card Request off of the case summary screen on kynect.

E. Requests for duplicate cards for SSI recipients are processed by DCBS staff. These cards are issued by accessing the MAID-ISS file off the Application Selection Screen on KAMES.

MS 1600 RETROACTIVE MEDICAID (1)

[Pregnant women, children, and former foster care youth are eligible for retroactive coverage if they have unpaid medical expenses in in any of the three months prior to the application month as long as they are technically AND financially eligible for MAGI Medicaid during the month of application.

Note: With the implementation of Kentucky HEALTH, individuals receiving Medicaid in the ADLT and PACA Type of Assistance (TOA) are not eligible for retroactive coverage.

A. An individual does not have to be ongoing eligible to receive retroactive MAGI Medicaid benefits.

B. Client attestation is acceptable for verification of medical expenses.

C. Retroactive benefits should only be issued for those months that the individual attests expenses were incurred.

Example: Sue applies for Medicaid in April and states that she has incurred medical expenses in January and March. Retroactive coverage should only be issued for those two months.

DO NOT issue retroactive coverage for months that an individual did not incur a medical expense.]

## MS 1900 INTRODUCTION TO MANAGED CARE (1)

Managed Care Organizations (MCOs) link Medicaid recipients with participating physicians who are responsible for coordinating and providing primary medical care to these recipients.

A. The purpose of managed care is to:

1. Assure access to needed care;

2. Provide for continuity of services;

3. Strengthen the patient/physician relationship;

4. Promote the educational and preventive aspects of health care;

5. Control unnecessary utilization and related cost; and

6. Improve the quality of care received.

B. The following Modified Adjusted Gross Income (MAGI) Medicaid recipients are exempt from enrolling with an MCO:

1. [Members in long term care (LTC) facilities such as nursing facilities, Hospice and Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID);]

2. Members receiving waiver services with the exception of Non-Institutionalized Hospice;

3. Members with eligibility that is time limited such as Spend Down and Time Limited Aliens;

C. [Non-exempt recipients are required to enroll with an MCO. Upon disposition of an application, if the worker does not enter shopping and assist the member in making their MCO selection, Worker Portal will trigger the auto assignment process. An MCO will be assigned for the member using auto assignment rules.]

D. Members also have the option of selecting a Primary Care Provider (PCP) in the shopping module after MCO selection. If a PCP is not selected after enrollment, the MCO will assist the member in selecting one. Members will receive a welcome packet from the MCO that includes a handbook and other instructional material.

E. Department for Medicaid Services (DMS) maintains a managed care toll-free telephone number to assist providers and recipients who have questions pertaining to managed care. The Managed Care Member Services phone number is 1-(855) 446-1245, and is available from 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday.

MS 1901 MANAGED CARE PROVIDERS (1)

[The Department for Medicaid Services (DMS) contracts with Managed Care Organizations (MCOs) to coordinate health care for most Medicaid (MA) members.

A. The following MCO providers are available to members in all MAGI Medicaid categories:

1. Aetna Better Health of Kentucky (formally known as Coventry Cares);]

2. Wellcare of Kentucky;

3. Humana;

4. Passport; and

5. Anthem

B. MCO website at https://prd.chfs.ky.gov/ManagedCare/ may be accessed by workers and recipients to search for:

1. Participating managed care providers and physicians in a particular county;

2. The MCO and ID number;

3. The provider's name, address, phone number, provider type, and the National Physicians Identification Number; or

4. The provider's Specialty.

C. Managed Care recipients may contact Managed Care Member Services for information at 1-855-446-1245.

MS 1902 MANAGED CARE DEFINITIONS (1)

The following is a list of definitions used for managed care:

[A. Managed Care Organization (MCO) – the name of the Kentucky plan approved by the Centers for Medicare and Medicaid Services (CMS), which administers managed care for Medicaid recipients through regional groupings of Medicaid providers.

The names of the KY MCO's and contact numbers are:

- Aetna Better Health of KY 1-855-300-5528
- WellCare of Kentucky 1-877-389-9457
- Humana 1-855-852-7005
- Passport 1-800-578-0603
- Anthem 1-855-690-7784]

B. Managed Care – the practice of making informed judgments of what an individual needs and managing treatment to ensure necessary and appropriate care is provided.

C. Partnership – A regional group of health care providers, such as doctors, hospitals, drug stores, therapists, and laboratories. Kentucky is divided into eight partnership regions. Each region has a unique name.

D. Partnership Region – A group of counties designated by the Department for Medicaid Services (DMS) as a geographical coverage area of a partnership health plan in Kentucky. There are eight regions in the state.

E. Primary Care Provider (PCP) – The provider or specialist selected by the recipient and/or assigned by MCO, who authorizes the recipient's healthcare. Workers are not involved in the PCP selection process, beyond capturing member preference during initial shopping. Recipients should contact their MCO for information about selecting or changing a PCP.

F. Behavioral Health Services – medical services related to the treatment of mental disorders and substance abuse.

MS 1903 MANAGED CARE ENROLLMENT (1)

Non-exempt Medicaid (MA) applicants are given the opportunity to select a Managed Care Organization (MCO) during the application process.

The individual may change an MCO/physician within the first 90 days of initial enrollment. This begins with the coverage start date under current enrollments on the Case Summary Page on Worker Portal. Members also have the opportunity to switch their MCO annually, during open enrollment periods, similar to private health insurance open enrollment.

A. During the application interview:

1. If the member is subject to managed care, provide a brief explanation of the managed care program;

2. If the member knows who their preferred MCO is, select from the shopping module on Worker Portal; and

3. If a member knows the Primary Care Provider (PCP) they wish to utilize, capture that information.

B. If the member does not know which MCO they wish to select during the application interview, Worker Portal will automatically assign an MCO once the application is disposed. Once the application has been disposed and the MCO selected, the Department for Community Based Services (DCBS) worker cannot complete an assignment on Worker Portal. The member will need to contact Managed Care Member Services at 1-855-446-1245 for any changes.

C. Once a member is approved for MA, they are contacted by their MCO for enrollment and selection of a PCP. Members are issued a one-time managed care card in addition to the KYHealth Card that is issued to all MA recipients. If members have specific managed care questions refer them to Managed Care Member Services at 1-855-446-1245 or their designated MCO. Toll-free telephone numbers are listed on the back of both cards.

D. For reapplications approved within 60 days of the effective date of discontinuance, members will be assigned to the same MCO unless a new provider is requested.

E. For member adds, follow procedures listed in items A, B, and C. If an individual is added to an active case, the effective date is the first day of the month of the requested change. If a member is eligible for retroactive MA, the effective date is the first day of month of prior eligibility.

F. Members who are exempt from managed care are issued a KYHealth Medicaid card.

G. There are no fair hearing procedures for managed care as the delivery method of MA is not a qualifying event for a fair hearing. Managed Care has a grievance procedure for issues such as dissatisfaction with a provider

assignment. These are explained in the member handbook which is issued upon request.

[H. A deemed eligible newborn is required to have the same MCO as the mother for the initial two months of MA eligibility.]

MS 2110 ENUMERATION (1)

[Each individual (including children) applying for MAGI Medicaid must provide his/her social security number (SSN). The Federal HUB will verify each individual's SSN with the Social Security Administration (SSA).]

Deemed eligible newborns are not required to provide an SSN during the deemed period.

A. If an individual has an SSN, but refuses to provide it or does not meet one of the acceptable exemptions below, that individual will be deemed ineligible. If the individual does not have an SSN or it is not verified, the individual is temporarily approved and given 90 days to provide verification.

B. The 90 day grace period is not allowed for individuals refusing to apply for an SSN, who are not deemed eligible and do not meet one of the acceptable exemption reasons below:

1. Religious objections;

2. Alien status; and

3. Only issued an SSN for valid non-work reasons.

C. Those individuals not seeking coverage for themselves, but who are included in the applicant's household, are not required to provide an SSN.

MS 2150 CITIZENSHIP AND IDENTITY REQUIREMENTS (1)

All individuals applying for Modified Adjusted Gross Income (MAGI) Medicaid must verify he/she is a United States (US) citizen or a Qualified Alien. Refer to Volume IVB, MS 2152 for Qualified Alien Criteria. Nationals of Puerto Rico, U.S. Virgin Islands, American Samoa, the Northern Mariana Islands or Swain's Island are equivalent to U.S. citizens. Individuals who are not US citizens or Qualified Aliens may still be eligible for time-limited Medicaid. See Volume IVB, MS 2160.

Substantiation of citizenship is an automated process performed by the Social Security Administration (SSA) and/or the Department of Homeland Security (DHS) for individuals who attest he/she is a citizen or LPR of the United States.

Identity is considered automatically verified upon documentation of citizenship or Lawful Present Resident.

Once the individual's SSN and citizenship have been verified and documented, he/she is no longer required to verify this information.

A. Substantiation of citizenship returns one of three results:

1. US Citizen;

2. Non-citizen; or

3. Additional information required.

B. [If citizenship is not verified, the case is temporarily approved and the individual will receive automatic notification that additional verification is required. Eligibility for Medicaid is granted to the individual for up to 90 days to provide the requested verification. If the individual provides verification, the status is changed to "verified." If no verification is provided or it is insufficient, benefits are terminated at the next administratively feasible month following the end of the 90 days. If the individual reapplies, the case will only pend for 30 days to allow the individual to return the proper verification.]

C. Citizenship requirements for all MA programs are as follows:

1. The following individuals are not required to verify citizenship:

   a. Deemed eligible newborns under age 1;
   b. Two-Month Emergency Time Limited Medicaid applicants;
   c. SSI individuals;
   d. Medicare recipients;
   e. Foster care children;
   f. Subsidized adoption Title IV-E children; and
   g. RSDI recipients receiving benefits based on disability.

2. All other individuals must present verification of citizenship. The document must be original and show a U.S. place of birth or verify that the person is a U.S. citizen. First look for verification of citizenship

from the primary tier, Tier 1. If verification cannot be obtained from Tier 1, look into subsequent tiers for possible acceptable forms of verification.

The following are the tiers of acceptable verification.

a. TIER 1 (highest reliability)

Acceptable primary documentation for identification and citizenship may be one of the following:

1) A U.S. Passport;
2) A Certificate of Naturalization (DHS Forms N-550 or N-570); or
3) A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561).

b. TIER 2 (satisfactory reliability)

Acceptable secondary documentation to verify proof of citizenship:

1) A Certification of Birth issued by the Department of State (Form DS-1350, FS-240 or FS-545);
2) A U.S. birth certificate. Workers may also utilize KVETS for verification by viewing the certificate online and documenting in comments. Workers may access the website for vital statistics to obtain information for the applicant/recipient on how they can request birth certificates from other states at http://www.vitalchek.com/listphone.asp;
3) A U.S. Citizen I.D. card (DHS Form I-197 or I-179);
4) An American Indian Card, Form I-872, issued by the Department of Homeland Security with the classification code "KIC";
5) Final adoption decree;
6 Evidence of Civil Service employment by the U.S. government before June 1976;
7) An official military record of service showing a U.S. place of birth; or
8) A Northern Mariana Identification Card, Form I-873.

c. TIER 3 (satisfactory reliability – use only when primary or secondary evidence is not available)

Acceptable third-level documentation to verify proof of citizenship:

1) U.S. hospital birth record on hospital letterhead that was created at least 5 years before the initial Medicaid application date and indicates a U.S. place of birth. (DO NOT accept a souvenir birth certificate.);
2) Life, Health or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial

application date;
3) Religious records recorded in the U.S. within three months of the birth; or
4) Early school records.

d. TIER 4 (lowest reliability)

Acceptable fourth-level documentation to verify proof of citizenship:

1) Birth records of citizenship filed with Vital Statistics within five years of the birth; or
2) Federal or State census record showing U.S. citizenship or a U.S. place of birth for persons born 1900 through 1950. The applicant or worker completes Form DC-600, Application for Search of Census Records and Proof of Age. In remarks, state U.S. citizenship data requested for Medicaid eligibility. This form is on the U.S. Census website at http://www.census.gov; or
3) Institutional admission papers from a nursing home, skilled nursing care facility or other institution that was created at least 5 years before the initial Medicaid application date and indicates a U.S. place of birth; or
4) A medical (clinic, doctor, or hospital) record that was created at least 5 years before the initial Medicaid application date that indicates a U.S. place of birth unless the application is for a child under age 5; or
5) Indian tribal records. Forward this type verification to the Medical Support and Benefits Branch (MSBB) for approval by the Department for Medicaid Services.

e. LAST RESORT

Notarized statements may be accepted for citizenship verification only when no other documentation is available. Naturalized citizens are permitted to utilize this process as well.

Procedures are as follows:

1) Written notarized statements MUST be signed under penalty of perjury, from two individuals of which only one can be related;
2) These two individuals MUST have personal knowledge of the events establishing the applicant's claim of citizenship. At least one statement must contain information regarding why other documentation is not available;
3) The person signing the notarized statement must provide proof of his/her own citizenship and identity.

As always, assist individuals who encounter any difficulty in obtaining documentation for verification of citizenship. Please be especially mindful of potential challenges facing the elderly, the disabled, the blind and those coping with other types of limitations.

MS 2152 CRITERIA FOR QUALIFIED ALIENS (1)

[To qualify for Modified Adjusted Gross Income (MAGI) Medicaid non-U.S. Citizens must meet qualified legal alien status. Qualified legal aliens are individuals lawfully admitted for permanent residence who have been granted legal immigration status through the U.S. Citizenship and Immigration Services (USCIS).

Please Note: Individuals with I-20 student visas do not meet the criteria for qualified alien status]

In addition, the Personal Responsibility and Work Opportunity Act imposed a 5 year ban from receiving Medicaid that affects certain qualified aliens who entered the U.S. after August 22, 1996.

A. The following qualified aliens are subject to the 5 year date of entry ban imposed by Medicaid and cannot receive MAGI Medicaid (except for the time-limited MA) until they have remained in qualified alien legal status for at least 5 years from their date of entry into the United States:

1. Aliens lawfully admitted for permanent residence ON or AFTER August 22, 1996;

2. Aliens paroled in the U.S. under Section 212(d)(5) of the Immigration and Nationality Act (INA) for a period of one year. If U.S. Citizenship and Immigration Services (USCIS) document I-94 indicates the individual will be in the U.S. for at least 1 year, eligibility may potentially start after parolee status is granted;

3. Any individuals listed in item B. 6 below that have a final, non-appealable, legally enforceable order of deportation or exclusion entered against them; they are NOT eligible under the provision listed below in B. 6;

4. Aliens who are battered or subjected to extreme cruelty in the U.S.

   a. Either as an adult or as a child if battered or subjected to extreme cruelty by:
      1) A spouse or parent of the alien without the active participation of the alien in the battery or cruelty; or
      2) A member of the spouse or parent's family residing in the same household as the alien – and the spouse or parent consented to the battery or cruelty.

   b. The battered individual must:

      1) No longer reside in the household with the individual responsible for the battery or cruelty;
      2) Have a substantial connection between the battery or cruelty and the need for the benefit; and
      3) Have been approved or has a petition pending for:

a) Status as a spouse or child of the U.S. Citizen;
b) Status as a permanent resident alien; or
c) Suspension of deportation status pursuant to Section 244 (a)(3) of the INA.B

Note: “Battered or subjected to extreme cruelty” means an individual who has been subjected to:

1) Physical acts that resulted in, or threatened to result in, physical injury to the individual;
2) Sexual abuse;
3) Sexual activity involving a dependent child;
4) Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities;
5) Threat of, or attempts at, physical or sexual abuse;
6) Mental abuse; or
7) Neglect or deprivation of medical care.

B. [The following qualified aliens are NOT subject to the 5-year ban and MAY receive MAGI Medicaid from their date of entry:

1. Children under the age of 19 who meet qualified alien criteria or are lawfully present;]

2. Aliens lawfully admitted for permanent residence before August 22, 1996;

3. Afghan and Iraqi aliens who are granted special immigration status under Section 1059 of the National Defense Authorization Act (NDAA) of 2006 or Section 1244 of the NDAA of 2009 are treated in the same manner as refugees admitted under Section 207 of the Immigrations and Nationality Act. These Iraqi and Afghan aliens served as translators for the U.S. military. This special immigration status also applies to their spouses and unmarried dependent children. The law applies to Afghan and Iraqi aliens who were already in the U.S. with special immigration status on the effective date of the law, December 19, 2009, and who enter on or after that date;

4. Refugees who were admitted under Section 207 of the INA and asylees who were granted asylum under Section 208 of the INA;

   Note: Sometimes refugees and asylees are granted permanent legal resident status after only 1 year of being admitted into the United States. Their status changes from being covered under sections 207 or 208 of the INA act to being covered under section 209 of the INA act. Individuals covered under sections 207, 208, or 209 are not subject to the 5 year entry ban.

5. Children under the Child Citizenship Act of 2000, who automatically acquire citizenship on the date that all of the following requirements are satisfied:
   a. At least one parent is a U.S. citizen whether by birth or naturalization;
   b. The child is under 18 years of age; and

c. The child is residing in the United States in the legal and physical custody of the citizen parent pursuant to the lawful admission for permanent residence.

Note: The parent can apply by completing a Form N-600, Certificate of Citizenship. They can also apply for a U.S. Passport. If the applicant has other documentation that verifies the parent to the child is a U.S. Citizen, such as the child's birth certificate or the parent's birth certificate, then this can be used and the Certificate of Citizenship would not be necessary.

6. Aliens who are verified by the Office of Refugee Resettlement (ORR) to be victims of human trafficking, and eligible relatives. Refer to Volume I, MS 0562;

7. Aliens granted status as Cuban or Haitian entrant (as defined by Section 501 (e) of the Refugee Assistance Act of 1980) whose I-94 is annotated with the words "refugee".

   Section 501 (e) defines Cuban and Haitian entrants as any individual who is:

   a. Granted parole status as a Cuban/Haitian entrant (status pending);
   b. Granted parole status as a Cuban/Haitian entrant under Section 212 which is considered in the same manner as those entering under Section 501;
   c. Granted any other special status established under INA laws for these nationals;
   d. Being a national of Cuba or Haiti paroled into the U.S. and has not acquired another status under INA;
   e. Subject to exclusion or deportation proceedings under INA; or
   f. Having an application for asylum pending with INS.

Note: If any of the individuals listed in item 6 have a final, non-appealable, legally enforceable order of deportation or exclusion entered against them, they are NOT eligible under this provision.

8. Aliens granted status as a Cuban or Haitian refugee who present an I-551 with a category status of 'CU6' (for Cuban refugee), 'HA6' (for Haitian National paroled under Haitian Refugee Fairness Act), or 'RE6' (Refugee who entered the U.S. on or after April 1, 1980);

9. Aliens admitted as an Amerasian immigrant under Section 584 of the Foreign Operations Export Financing and Related Programs Appropriation Act of 1988 (letter coded AM-1, Am-2, AM-3, AM-6, AM-7, and AM-8);

10. Aliens whose deportation is being withheld (I-94 annotated with the words political asylees) under Section 243 (h) of the INA or after April 1, 1997, the renumbered Section 241 (b) of the INA;

11. Permanent resident aliens who are veterans honorably discharged for reasons other than alienage, their spouses or unmarried dependent

children;

12. Permanent resident aliens who are on active duty, other than active duty for training in the Armed Forces of the United States and fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d), their spouses or unmarried dependent children;

13. Aliens who are granted conditional entry pursuant to Section 203(a) (7) of the INA as in effect prior to 4/1/1980.

C. Aliens designated as PRUCOL, permanently residing under color of law, are NOT eligible for MAGI Medicaid (except for time-limited MA, see MS 2160).

MS 2160* TIME-LIMITED MA ELIGIBILITY (1)

Effective January 1st, 2014 any alien, legal, illegal or legalized who does not meet the qualified alien requirements for ongoing Modified Adjusted Gross Income (MAGI) Medicaid, may be eligible for time-limited MA due to an emergency medical condition, if eligibility requirements are met. Aliens currently in this country on a temporary visa, including students and tourists, may be eligible for time-limited emergency Medicaid coverage, if eligibility requirements are met.

A. Individuals must still meet all financial and technical requirements for MAGI Medicaid with the exception of enumeration to be eligible for time-limited coverage. Use procedures outlined in Volume IVB to determine program category, technical, and financial eligibility. Kentucky Children Health Insurance Program (KCHIP) does not provide time-limited coverage for those individuals in the P7 category.

B. Aliens applying for time-limited MA due to an emergency medical condition are exempt from enumeration requirements. Enter the SSN if provided, but do not require application for an SSN.

C. Time-limited MA coverage includes the first day of the month in which the emergency medical condition begins and continues through the following month.

D. Time-limited MA coverage does not include coverage for organ transplant procedure.

E. An emergency medical condition is defined as a medical condition in which the absence of immediate medical treatment could result in:

1. Placing the patient's health in serious jeopardy;

2. Serious impairment to bodily functions; or

2. Serious dysfunction of any bodily organ.

F. Verify the emergency medical condition by obtaining a written statement from the medical provider. The statement must contain the following information:

1. Information about the medical condition;

2. The date of the emergency treatment; and

3. Indicate the medical provider considers the condition an emergency medical condition.

G. If the statement is lacking information or the information is unclear, contact the medical provider for additional information or clarification. This contact may be done by telephone or letter. All clarifying information not included in the written statement must be clarified in case notes.

H. The emergency medical condition must have occurred in the month of application or within the 3 months prior to application.

I. The normal delivery of a baby is considered an emergency and a covered service and the following conditions apply:

1. The MA eligibility only covers the month of delivery and the following month;

2. The individual is not eligible for postpartum coverage; and

3. The newborn is considered deemed eligible.

MS 2162* EXTENSION OF TIME LIMITED MA (1)

An extension of time-limited MA may be requested by a recipient if the emergency medical condition continues. The individual must file a new application and submit a new physician's statement verifying the emergency event is an on-going/continuing condition.

A. An extension of time-limited emergency medical coverage for a non-qualified alien is based on an approval by the Department for Medicaid Services (DMS).

1. The extension request must be received by the Medical Support and Benefits Branch (MSBB) within 30 days of the end of the emergency Medicaid eligibility period. MSBB forwards the request to DMS.

2. For aliens who request additional coverage 30 days beyond the expiration of the eligibility period, send form MA-105, Notice of Eligibility or Ineligibility, for denials of the extensions.

B. Obtain a new written statement from the medical provider verifying that the emergency medical condition will exist for a period beyond the time-limited coverage.

1. The new statement must contain detailed information regarding the recipient's emergency medical condition including the medical provider's estimate of how long the emergency medical condition will continue;

2. Scan the written statement into Electronic Case Files (ECF); and

3. Thoroughly document case notes than an extension has been requested.

C. Complete all the applicable entries on form MA-33, Department for Community Based Services Medical Support and Benefits Branch DMS Review/Cover Letter and forward to MSBB mailbox at DFS.Medicaid@ky.gov via regional office.

D. MSBB forwards the request to DMS who approves or denies the extension. For approvals, DMS provides the effective dates of the extension.

F. MSBB notifies field staff through regional contacts of the decision.

G. Upon receipt of an extension approval or denial, update the case accordingly.

MS 2200 RESIDENCY (1)

[In order to be eligible for Medicaid an individual must be a resident of Kentucky and intend to remain. An individual does not have to reside in the state for any specified amount of time to be considered a resident.]

If residency criteria are not satisfied, the application will pend and at the end of 30 days, the application will deny.

State residency is based on client statement unless conflicting information is returned from a trusted data source such as returned mail from the Post Office or a Public Assistance Reporting Information System (PARIS) match is received. If there is reason to doubt, the request for information (RFI) process will be initiated and the client will be given 30 days to provide verification.

State residency is verified individually for each member in the household.

Do not deny MA because the individual:

1. Has not lived in the state for a specified period; or

2. Does not maintain a fixed or permanent address.

Kentucky residents that are temporarily absent are considered residents as long as they state they intend to reside in Kentucky.

MS 2350 INCARCERATION (1)

An inmate of a prison, county jail, or similar facility is not eligible for benefits though the Kentucky Health Benefit Exchange (KHBE), including Modified Adjusted Gross Income (MAGI) Medicaid, enrollment in an Advanced Premium Tax Credit (APTC), Cost Sharing Reduction(CSR) or Qualified Health Plan (QHP).

A. **[**The following individuals are **NOT** considered incarcerated:

1. Individuals residing in a halfway house;

2. Individuals on house arrest; and

3. Individuals sentenced to week-end jail. (These individuals are eligible for Medicaid; however, any expenses incurred while incarcerated on the week-end are the responsibility of the jail.)**]**

B. Self-attestation is acceptable for non-incarceration status unless there is reason to doubt or worker has received information not consistent with the internal data sources.

C. Medicaid cases will pend at application and recertification if client stated information regarding incarceration is inconsistent with data sources. An individual is given 30 days to verify non-incarceration. If verification is not provided, the individual will be denied or discontinued for incarceration.

D. Federal Data sources will conduct ongoing checks for changes in non-incarceration status. If an individual is determined to be incarcerated, Medicaid benefits will be terminated at the next administratively feasible month.

E. APTC, CSR, and QHP **will** approve if the information given is inconsistent with trusted data sources. In these situations, the individual is given 90 days to verify non-incarceration. If non-incarceration is not verified at the end of 90 days the case will terminate at the next administratively feasible month.

MS 2600* PREGNANCY (1)

Client attestation is sufficient for verification of pregnancy and due date unless there is reason to doubt.

Medicaid coverage will be given through the estimated due date plus the post-partum period.

The following conditions are applicable in this category:

A. Post-partum begins the date the pregnancy ends and extends 60 days, ending the last day of the month in which the 60 days concludes. In order to be eligible for post-partum coverage, a woman must be eligible for Medicaid when the child is born.

B. Once the benefits are determined, the client continues to receive through the post-partum period regardless of situation unless she moves out of state.

C. If the pregnancy is terminated for any reason, post-partum coverage will be given to the client.

D. If the client reports any due date changes, the length of coverage will be re-determined.

If the pregnancy estimated due date has passed and client has not reported any changes, the system will automatically discontinue pregnancy-related Medicaid benefits at the next administratively feasible month.

If a woman enrolled in the Low Income Adult category later becomes pregnant, she will automatically be enrolled in the Pregnant Women category once the information is known to the agency. After post-partum eligibility ends, she will be returned to the Adult category unless eligible in another category.

## MS 2645 PRIVATE NON-PROFIT ADOPTIONS OVERVIEW (1)

Once an adoption is final, a child in a private non-profit adoption is considered the same as any other child in a parent's case. The family may apply for Modified Adjusted Gross Income (MAGI) Medicaid and eligibility will be determined based on the household's financial situation.

If the adoption proceedings are pending the following criteria applies:

A. If the private non-profit adoption agency is not registered with the Office of the Inspector General (OIG) during the adoption proceedings the expenses paid for any purpose related to the non-profit adoption shall be submitted to the court, supported by an affidavit, setting forth in detail a listing of expenses for the court's approval or modification.

If the private non-profit adoption agency refuses to include reimbursement for medical expenses paid by Medicaid, the child is not technically eligible for medical assistance.

B. If the private non-profit adoption agency is registered with the Office of the Inspector General (OIG) the affidavit and Medicaid reimbursement requirements do not apply. These agencies are exempt from providing the documentation outlined in item A.

To view a listing of the agencies registered with OIG refer to http://chfs.ky.gov/os/oig/drcc. Scroll to the bottom of the website and under the DRCC Directories section click on the Child Placing Agencies Directory.

For the children meeting the criteria in items A or B the following procedure is followed:

1. [The child is entered on Worker Portal and the worker should review the situation to determine if the child meets criteria for deemed eligibility;]

2. The case is in the child's name;

3. Inquire if parental rights are terminated. Annotate this information in case notes;

4. Ask if the adoption agency carries health insurance on the child. Annotate this information in case notes; and

5. All required verification must be provided.

Note: If the adoption is subsidized, the adoptive parents will have a copy of the subsidy agreement. Subsidized adoptions are handled through the Division for Protection and Permanency (DPP). These cases are Non-MAGI and are processed by the Children's Benefits Worker (CBW). There are no special cases for adopted children unless the adoption is subsidized by the state.

MS 2650 DEEMED ELIGIBLE NEWBORNS (1)

[A child under 1 year of age born to a mother who received Medicaid (MA) in Kentucky at the time of the newborn's birth is considered deemed eligible. This includes receipt of Medicaid in any category, including Modified Adjusted Gross Income (MAGI) Medicaid, Non-MAGI Medicaid, Time-Limited Medicaid, and SSI.]

Once deemed eligible, the newborn is guaranteed Medicaid from the birth month through the 12th month regardless of whether the mother and/or other case members remain eligible to receive Medicaid. Medicaid must be issued for a deemed eligible newborn even if the mother does not want the coverage.

A. A child is considered a deemed eligible newborn even in situations where:

1. The Medicaid application for the mother is made after the birth of the newborn, as long as the birth month is the month of application or one of the 3 retroactive months for which the mother is approved.

2. The mother is approved for Spend Down eligibility and the excess is obligated on or before the newborn's date of birth.

B. Worker Portal will interface with Vital Statistics regarding newborns. If the mother's case is identified on Worker Portal, the deemed eligible newborn will be automatically added to the case and coverage will be issued. If the mother's information is not found on Worker Portal, the newborn information will be sent to the Department for Medicaid Services (DMS) for resolution.

C. [If the deemed eligible newborn's birth information is reported to the Department for Community Based Services (DCBS) and the newborn is not active on Worker Portal, action must be taken to add the child and issue coverage.

D. If the newborn's mother receives MA in a Foster Care, Subsidized Adoption, or DJJ case set up a separate case for the newborn.

E. After the newborn's first birthday, all technical and financial eligibility requirements must be met for the child to continue to receive MAGI Medicaid. If a child's birthday is after the first day of the month, deemed eligibility ends that month.

For example: A deemed eligible child's date of birth is 5/15/15, therefore deemed eligibility will end 5/31/16 and the child must meet all eligibility requirements effective 6/1/16 in order to continue to be eligible for MAGI Medicaid

If the child's birthday is the first day of the month, deemed eligibility ends the prior month.

For example: A deemed eligible child's date of birth is 5/1/15, therefore deemed eligibility will end 4/30/16 and the child must meet all eligibility requirements effective 5/1/2016 in order to be continued eligible for MAGI Medicaid.]

MS 2700* MAGI SPEND DOWN PROCESS (1)

Modified Adjusted Gross Income (MAGI) spend down provides time-limited Medicaid (MA) to individuals in all MAGI categories, except Low Income Adults, who meet technical requirements but have income in excess of the appropriate Federal Poverty (FPL) Scale for the Eligibility Determination Group (EDG) size.

MAGI spend down eligibility is explored only in the retro quarter due to potential ongoing eligibility for Advance Premium Tax Credit (APTC). Individuals may apply for a retro spend down the following month(s) provided they were not approved APTC and enrolled in a Qualified Health Plan (QHP) during the month the medical expense was incurred.

Example: Bob had surgery on 2/5/16 and applies for financial assistance on 2/10/16. He is technically eligible in the PACA category but over the income limit for MA and is approved APTC. He enrolls in a QHP effective 3/1/2016; however wishes to explore potential spend down eligibility for February due to medical expenses. Bob should be advised to apply for retroactive spend down coverage the following month.

Worker Portal reviews for regular MA eligibility before it determines spend down eligibility. Eligibility may be established only for a RETROACTIVE quarter and may include any of the three prior months from the month of application during which an applicant incurred a medical expense. Which months are included in the retroactive quarter is a decision left up to the applicant as eligibility may be established for only one or two months of the RETROACTIVE quarter even if there are medical bills in the other months.

A. To determine eligibility for the RETROACTIVE quarter spend down the following applies:

   1. The applicant must verify the actual MEDICAL EXPENSES that were incurred in any of the retroactive months for which the spend down application is made. The medical bills used must be currently owed. The bills can be owed by any member of the MA household even if that member is not applying for or receiving MA. However, if the medical bills have been turned over to a collection agency, the bills are no longer considered as owed and cannot be used. Any bills already used in a previous spend down approval cannot be used again for the current application; and

   2. The applicant must verify INCOME received in any of the retroactive months for which a spend down application is made.

B. Spend down MA eligibility begins on the day an individual meets the spend down obligation amount; i.e., the day medical expenses equal or exceed the excess income amount. Advise recipients the spend down obligated amount is met with medical bills incurred by any case member during the spend down time period. The household's obligated amount is met with the first providers who bill MA. Use medical expenses that are incurred during the quarter or currently owed from a prior period that was not previously covered by spend down or regular MA.

Example: The spend down obligation amount is $1200.00 for the spend down period of 3/23/16 through 5/31/16. The household is responsible for payment of bills prior to 3/23/16 used to meet the obligated spend down amount, as well as the $1200.00 spend down obligation. If the first bill received by DMS is for services on 4/6/16 for $600.00, the amount of that bill are deducted from the obligated amount of $1200.00. The next bill received by DMS is $300.00 for services on 3/23/16, and a bill is submitted the same day to DMS for $300.00 for services on 5/1/16. These are deducted from the obligated amount, the client is responsible for paying them, and the spend down obligated amount is met. Any subsequent bills are paid by DMS as long as they are within the spend down period of 3/23/16 through 5/31/16.

If an individual has a large bill covering several days, it is appropriate to enter daily amounts rather than the total so that worker portal can determine the correct date the individual met the spend down obligation.

Example: Mary applies for retroactive spend down coverage on 3/1/16. Her spend down obligated amount is $1600.00. She was hospitalized 2/6/16 through 2/10/16 and the total bill is $ 9000.00. The itemized bill provided shows that Mary was charged $1500.00 on 2/6/16, $2500.00 on 2/7/16, $2500.00 on 2/8/16, and $1500.00 on 2/9/16, and $1000.00 on 2/10/16. By entering the daily amounts, Worker Portal will correctly determine that Mary met her spend down obligation on 2/7/16.

C. Notices for spend downs show the case obligation amount rather than the individual's obligation amount. The obligation amount is the amount the client must pay for the spend down time period.

D. If health insurance coverage other than MA exists, that insurance provider's payment for the incurred services must be determined prior to approving the spend down application. Only the amount the individual is responsible to pay can be considered towards the spend down excess.

E. When quarterly excess income equals verified recognized incurred medical expenses, paid or owed, the application may be approved on a time-limited basis. Effective dates of coverage begin on a specific day and end on the last day of the month approved.

F. A spend down application is approved as soon as possible, but not to exceed 30 days from the date of application unless additional time is requested by the applicant. When the verification is received, the case must be worked WITHIN 7 WORK DAYS from receipt of the required verification or the 30$^{th}$ day, whichever is first.

G. Advise recipients they need to wait until they receive a statement from the provider that DMS has been billed, and the bill was denied for use in meeting the obligated amount, before they make any payments for services during the spend down timeframe. This is necessary to establish which provider bills are adjusted based on the family/member's obligation amount.

H. If, after a determination has been made, additional verification of medical expenses are provided by the recipient, a recomputation is completed.

1. If it is determined that the spend down liability was met earlier in the quarter, complete a Special Circumstance Transaction to authorize MA eligibility for the earlier date.

2. If the re-computation results in the determination that the applicant met the spend down liability later in the quarter, no action is required.

I. If medical expenses for the requested period (one, two, or three months) are less than the excess income, deny the application.

Example: Sue requests a one month spend down and her excess income is 1000.00, however total medical expenses are 800.00.

## MS 2710* MEDICAL EXPENSES IN MAGI SPEND DOWN (1)

Spend down medical expenses are expenses incurred by an individual, a spouse or dependent child under 21 in the home or away from home for school attendance. Unless already receiving Medicaid (MA), these expenses are allowed regardless of whether or not these family members are included in the case and/or regardless of whether or not their income is considered in the MA eligibility determination.

A. Consideration of Medical Expenses:

1. Consider any verified allowable medical expense(s) incurred DURING the retro quarter. Begin with the first day of the quarter and list daily expenses.

2. Consider the unpaid balance of any verified allowable medical expense incurred PRIOR TO the established quarter.

   a. Consider the expense as incurred on the first day of the first month of the established quarter.

      1) When using prior medical expenses to meet the spend down amount, always show the date the expense was incurred as the first day of the spend down quarter. If the spend down amount is met with prior medical expenses only, the member spend down liability will be $0.

      2) Unpaid medical expenses from a prior quarter must be verified as still owed. If the bill has been written off or has been paid by a third party, it cannot be used. If verification cannot be provided that the bill is still owed, it cannot be used to meet the spend down liability.

   b. Consider only the portion of the expense needed to obligate the spend down excess.

      1) If consideration of a portion of the expense obligates the spend down excess, then the remaining balance of the expense can be used to obligate a future spend down excess. For these situations, annotate the amount used to obligate the excess for the established quarter, and the amount remaining for future spend down use in case comments.

      2) Review the case record to ensure the medical expense has not been considered in a previous quarter to establish MA eligibility.

         EXAMPLE: An individual's spend down excess for the prior quarter is $1,200. Two years ago, the individual incurred a $1,600 hospital bill, made a payment of $100 leaving an unpaid balance of $1,500. The $1,200 portion of the hospital bill is considered on the first day of the first month of the retro quarter for spend down. The remaining $300 of the bill can be used to obligate a future spend down excess.

3. Verified payments on medical bills for services when MA was not received are deducted if paid during the quarter.

   EXAMPLE: Two years ago, an individual purchased an $800 hearing aid and charged the full amount. Every month a $25 payment is made on the account. The individual applies for a MA spend down case. Consider the $25 as an allowable medical expense and record as a spend down expense the day the $25 payment is made.

4. When all verified allowable medical expenses presented by the individual are recorded, determine if, on any day in the quarter, the total amount of expenses for the period is as much as the excess income.

B. Verification of Medical Expenses:

1. Medical bills or statements;

2. Receipts for payment of medical expenses;

3. Medicare Summary Notices (MSN) which shows covered/uncovered and aid/unpaid medical expenses;

4. Health insurance statements showing amount paid;

5. Other appropriate means.

C. Medical Expense Restrictions:

1. Do not list any expense to be paid by a third party, such as Medicare, health insurance, insurance settlement, family members, etc. with the following exceptions:

   a. DO NOT hold spend down applications pending for verification of payment of medical expenses as a result of an unforeseen accident which may be covered by liability insurance owned by another person. It is the responsibility of DMS to obtain reimbursements from third party liability sources. This procedure does not apply to health insurance policies, such as, Medicare, Blue Cross/Blue Shield, Humana, etc. and Worker's Compensation. Spend down applications are held pending verification of payment of medical expenses by these third party liability sources.

   b. For persons undergoing renal dialysis treatment, do not hold spend down applications pending for Medicare Summary Notices (MSN) if the following applies as these cases are given priority and processed as soon as the spend down liability is met:

      1) They have Medicare but no other health insurance;

      2) The renal dialysis clinic provides a statement verifying the date of service, cost of service and the anticipated amount of Medicare reimbursement for each date of service. The difference between the

Medicare billed amount and the anticipated Medicare payment amount is allowed as the spend down medical expense.

Use this statement and any other verified medical expenses that will not be reimbursed by Medicaid, such as prescriptions. Other verified medical expenses subject to Medicare reimbursement cannot be used to meet the spend down liability as the application is to be processed prior to receipt of the MSN; and

3) When MSN's are received for other medical expenses, the case is reworked at the individual's request, to determine if an earlier date was met for the spend down program.

2. Unpaid medical expenses are allowed as a spend down medical expense however:

a. Do not consider medical expenses for which individual is absolved from payment, such as a medical bill written off by provider as uncollectible. If the medical expense is more than 90 days old, OR if the individual's responsibility for payment of the medical expense is questionable, the appropriate provider MUST be contacted to determine whether or not the individual is liable for payment of the expense.

b. Do not consider medical bills or payment on medical bills used to obligate the liability amount for any previous spend down quarter.

EXAMPLE: During the current quarter, an individual purchased eyeglasses costing $129. The total amount was charged on the 6th day of the 1st month of the current quarter. The total amount is considered on the 6th for spend down. During the next quarter, $25 a month has been paid on the $129 charge. The $25 payments cannot be used as the entire $129 was used in the quarter the expense was incurred.

3. All bills, statements, and receipts, must show the actual date of service and daily charge to determine the day the excess is met.

4. Deductions for prescription drug expenses incurred during a period of MA eligibility may be allowed ONLY if the recipient verifies that MA denied coverage of the drug at the time, and that a prior authorization request was also denied. A deduction can be given for a Medicare Part D premium if paid by the recipient.

D. Allowable Spend Down Medical Expenses

The following are allowable medical expenses used in determining spend down eligibility:

1. Health insurance premiums including SMI, and specified disease policies such as cancer and/or any other policies paying for services within the scope of the program. Consider the entire amount when paid or prorate payment for months of actual coverage, to the benefit of the individual whichever they choose.

EXAMPLE: A $90 premium is paid July 15 to cover August, September and October. Allow $30 for August 1, September 1 and October 1 or use the entire $90 on July 15.

2. Insurance policies paying specific benefits per day to an individual while hospitalized or during recuperation. Premiums paid on these policies are considered a medical expense.

3. Nursing facility insurance premiums.

4. Transportation expenses for health care that are not available free of charge. Costs for use of the individual's own are are deductible at the state rate per mile;

5. The actual amount paid for caretaker, Family Care or Personal Care services if the individual is paying the private pay rate. If medical expenses of a spouse are being considered and the spouse is receiving state supplementation payments then consider the payment for caretaker services as a medical expense.

6. In-patient hospital services including services in institutions for tuberculosis, mental disease or other specialty hospitals regardless of age;

7. Laboratory and x-ray services;

8. Nursing Facility services, including services in institutions for tuberculosis or mental disease, for all individuals regardless of age;

9. Any physician's services;

10. Medical care or any other type of remedial care recognized under state law furnished by licensed practitioners within the scope of their practice as defined by state law;

11. Home health care services, including intermittent or part-time services of a nurse or home health aide according to a physician's plan of treatment;

12. Private duty nursing services by a Licensed Practical Nurse or Registered Nurse;

13. Clinic services;

14. Dental services, including dentures prescribed by a licenses and practicing dentist;

15. Physical therapy and related services including supplies such as hearing aids;

16. Drugs prescribed by a licensed physician, osteopath, or dentist;

17. Prosthetic devices, including braces and artificial limbs;

18. Eye glasses and other aids to vision, prescribed by an ophthalmologist or an optometrist;

19. Ambulance services when medically indicated and/or other transportation cost necessary to secure a medical exam or treatment;

20. X-ray, radium and radioactive isotope therapy;

21. Surgical dressings, splints, casts and other devices used for reduction of fractures and dislocations and related items used at the direction of physician for the continuing treatment of a health problem;

22. If not available from a Home Health Agency, rental or purchase of durable medical equipment including, but not limited to iron lung, oxygen tents, hospital beds, wheelchairs, crutches, braces and artificial limbs including replacements if required because of change in the patient's condition;

23. Purchase, care and Maintenance costs of Seeing Eye Dogs:

24. Consider the cost of lodging, which may include the lodging cost of a nurse/attendant, a necessary medical expense if it can be determined lodging was necessary to secure required medical service or treatment.

    a. Question the individual to determine if circumstances necessitated lodging and explain in case comments.

    b. If the need for lodging cannot be determined, request a physician's statement to verify reported expenses were actually medically necessary.

    c. The allowable amount may not exceed commercial lodging costs prevalent in area.

25. Incurred medical expenses paid by a public program of the State or a political subdivision without federally designated funds. Political subdivisions include city, county, or local governments.

    a. Examples of public programs of the State include hospitals, health departments, community service centers, primary care centers operated by local health departments, and comprehensive care centers.

    b. Medical expenses paid by programs of the federal government including Medicare and VA. Bills that have been written off as uncollectible are not allowable as spend down deductions.

    c. Obtain a copy of the bill to verify that a medical expense was incurred and that the expense was paid by a state public program or political subdivision without federally designated funds prior to allowing the deduction.

26. Any item verified per a doctor’s statement that is medically necessary for controlling a patient’s allergy problem such as purchase of electrostatic air

filters, humidifiers, air conditioner, central heating system, hardwood floors, payment for carpet/upholstered furniture clearing, and carpet removal.

27. Other items clearly identified as medical in nature such as aspirin, antacids, peroxide, Band-Aids, nutritional supplements such as Ensure, and incontinent care products. Cash register receipts are acceptable verification of the expense. If the receipt does not specify the item, the individual's statement is accepted.

28. Consider charges from a physician who is not enrolled in the MA program as a medical expense, however even though the expense can be deducted, MA cannot make payments to a physician who is not enrolled an enrolled provider.

MS 2900 MAGI HOUSEHOLD DETERMINATION (1)

[For Modified Adjusted Gross Income (MAGI) Medicaid, household composition is determined based on Filer or Non-Filer rules. Each individual is designated a Filer or a Non-Filer based on tax filing status.]

Once designated either a Filer or Non-Filer, an Eligibility Determination Group (EDG) is constructed for each eligible individual. The EDG determines the household size and income that is considered for each individual. An individual DOES NOT have to be applying for assistance to be included in an EDG.

A. Filer Group: This includes those individuals considered either a tax filer or a tax dependent:

1. A tax filer is an individual who intends to file an income tax return for the benefit year and no other tax payer will claim this person as a dependent. This includes spouses filing a joint income tax return; or

2. A tax dependent is an individual for whom someone else claims a personal exemption deduction during the taxable year.

The EDG for an individual designated a Filer includes all members of the tax household. This determination is made based on client attestation on how the individual intends to file federal income taxes the next possible filing year. All members of the tax household are included in the EDG regardless of living situation.

B. Non-Filer Group: This is an individual who either does not intend to file taxes or meets one of exceptions listed below. These exceptions apply only to those individuals under the age of 19:

1. The individual expects to be claimed as a dependent by someone other than a spouse, biological, adopted or step-parent;

2. A child under the age of 19 living with both parents and the parents do not intend to file jointly;

3. A child under age 19 who will be claimed by a non-custodial parent; or

The EDG for an individual considered a non-filer includes the individual plus the following members if living together:

a. Spouse;
b. The individual's children if they are under the age of 19; and
c. If the individual is under age 19, includes the individual's parents and any siblings under the age of 19.

Note: Spouses who reside together count in each other's EDG, regardless of tax filing status.

EDG Examples

Example: #1: A Household applying for financial assistance for all members includes unmarried parents and their 3 children, ages 4, 6, and 10. They state they do not intend to file taxes; therefore, all members fall under Non-Filer rules.

The children's EDG size is 5 as they are all under the age of 19 and included are their siblings and parents.

Each parent's EDG is 4 including the parent and all children under the age of 19. They would not be included in each other's EDG as they are not married.

Example #2: Mother applies for financial assistance for herself and her 10 year old son. She states she files single and the child will be claimed as a dependent by a noncustodial parent for the next tax year.

The child's EDG is 2 as he meets one of the exceptions listed above and falls under Non-Filer rules. Non-Filer rules state to include parents who are living with any child under the age of 19.

The mother's EDG is 1 as she falls under Filer rules and this includes only her tax household.

Example #3: Grandmother is applying for financial assistance for herself and her 14 year old granddaughter. She files as head of household with the granddaughter as her dependent.

The child's EDG is 1 as she falls under Non-Filer rules. She is being claimed by someone other than a parent and therefore meets an exception.

The grandmother's EDG is 2 as she falls under Filer rules and included is everyone in her tax household.

Example #4: The household consists of married parents and their minor child. They state they intend to file a joint income tax return for the benefit year with minor child as a dependent.

The parents meet the definition of a tax filer and the child meets the definition of a tax dependent. Therefore all three fall under Filer rules and all members of the tax household would be included in each other's EDG. This would be an EDG size of 3 for each member.

Example #5: A 23 year old individual applies for financial assistance. He states he is a full-time student who maintains his own residence, but is claimed as a dependent on his parent's taxes. He states his parent's file "married filing jointly," and he is the only dependent claimed.

The 23 year old meets the definition of a tax dependent, therefore he falls under Filer rules and his EDG would be 3. His parents are included in his EDG even though they are not applying for assistance.

Note: If he works and files taxes to recover his withholdings, he is both a filer and dependent. Medicaid defaults to dependent rules in these situations.

Example #6: A 35 year old applies for financial assistance. She states that she files as head of household and claims her 63 year old mother as a dependent. She meets the definition of a tax filer and falls under Filer rules.

EDG size is 2. EDG includes her and her mother as no exceptions apply and therefore is based on tax household.

Example #7: A 40 year old applies for financial assistance and is the only member of the household. He states he files taxes and claims his 14 year old son, who resides with the mother, as a dependent.

His EDG would be 2 as he follows Filer rules and includes everyone in his tax household.

Example #8: A 60 year old man and his 24 year old son reside together and both are applying for financial assistance. The father states he is a tax filer and claims his adult son as a dependent.

The EDG size is 2 for both members. EDG is determined by tax household as no exceptions apply in this situation.

Example #9: A 30 year old woman applies for financial assistance. She resides with her mother and states she files taxes as “single” and is not a dependent in any other tax household.

Her EDG size is 1. No exceptions apply and therefore the EDG is determined by tax household.

MS 2910 MAGI INCOME SCALES (1)

Modified Adjusted Gross Income (MAGI) income is compared to the appropriate Federal Poverty Level (FPL) for the Eligibility Determination Group (EDG) size for MAGI Medicaid categories for Children under age 19, Pregnant Women, and Low Income Adults.

Individuals in the Parent/Caretaker Relative category of MAGI Medicaid are compared to the current MAGI MA scale.

A. All Types of Assistance (TOA) other than CHL4 and CHEX are allowed a 5% disregard if needed to gain eligibility. If income exceeds the initial income limit, 5% is added to the FPL for the appropriate EDG size and income is compared to the increased scale. Worker Portal automatically compares the income to the appropriate FPL plus 5% if necessary for eligibility.

   For example, if an individual in the Low-income Adult category has income that exceeds 133%; the countable income is compared to 138% FPL for determining eligibility.

   The FPL chart below outlines the appropriate FPL for APTC, CSR, and the MAGI Medicaid categories of Children under 19, Pregnant Women, and Low Income Adults:

| TOA | Category | FPL | With 5% disregard |
|---|---|---|---|
| TP45 | Deemed Eligible Newborn | N/A | N/A |
| CHL4 | Medicaid Children age 6-18 | 109% | N/A |
| CHL2 | Medicaid Children Under age 6 | 142% | 147% |
| CHL3 | Medicaid Children age 6-18 | 142% | 147% |
| CHL1 | Medicaid Infants under 1 | 195% | 200% |
| CHEX | KCHIP for children ages 0 -19 | 159% | N/A |
| CHIP | KCHIP for children ages 1 -19 | 213% | 218% |
| PREG | Pregnant Women | 195% | 200% |
| ADLT | Low-income Adult 19 – 64 | 133% | 138% |

B. If total countable income is equal to or less than the appropriate FPL scale for the EDG size, income eligibility is met.

C. The Medicaid EDG will include any unborn children of a pregnant woman.

D. [MAGI Medicaid uses current FPL income limits in the eligibility determination. Refer to the chart below for MAGI Medicaid income limits effective 4/1/18:]

| EDG Size | 109% | 133% | 138% | 142% | 147% | 159% | 195% | 200% | 213% | 218% | 250% |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1,103 | 1,346 | 1,396 | 1,437 | 1,487 | 1,609 | 1,973 | 2,023 | 2,155 | 2,205 | 2,529 |
| 2 | 1,495 | 1,824 | 1,893 | 1,948 | 2,016 | 2,181 | 2,675 | 2,743 | 2,922 | 2,990 | 3,429 |
| 3 | 1,888 | 2,303 | 2,390 | 2,459 | 2,546 | 2,753 | 3,377 | 3,463 | 3,688 | 3,775 | 4,329 |
| 4 | 2,280 | 2,782 | 2,886 | 2,970 | 3,075 | 3,326 | 4,079 | 4,183 | 4,455 | 4,560 | 5,229 |
| 5 | 2,672 | 3,261 | 3,383 | 3,481 | 3,604 | 3,898 | 4,781 | 4,903 | 5,222 | 5,345 | 6,129 |
| 6 | 3,065 | 3,740 | 3,880 | 3,993 | 4,133 | 4,471 | 5,483 | 5,623 | 5,989 | 6,129 | 7,029 |
| 7 | 3,457 | 4,218 | 4,377 | 4,504 | 4,662 | 5,043 | 6,185 | 6,343 | 6,756 | 6,914 | 7,929 |
| 8 | 3,850 | 4,697 | 4,874 | 5,015 | 5,192 | 5,615 | 6,887 | 7,063 | 7,522 | 7,699 | 8,829 |

E. Income for individuals in the Parent/Caretaker Relative category is compared to the current MAGI MA scale below:

| EDG SIZE | Standard | With Disregard |
|---|---|---|
| 1 | 235 | 284 |
| 2 | 291 | 357 |
| 3 | 338 | 421 |
| 4 | 419 | 519 |
| 5 | 492 | 609 |
| 6 | 556 | 690 |
| 7 | 621 | 772 |
| 8 | 687 | 855 |

F. Individuals determined over the income limit in the Parent/Caretaker Relative category automatically have eligibility explored in the Low Income Adult category.

MS 3000 INCOME ELIGIBLITY (1)

[Income is considered verified for Modified Adjusted Gross Income (MAGI) Medicaid when the client stated amount and that received from the trusted data source is reasonably compatible. Reasonable compatibility is defined as a 10 percent difference between the self-attested amount and the information returned by the trusted data sources.]

If income information is returned by the trusted data sources and is not within the reasonable compatibility, the individual is given the opportunity to provide satisfactory documentation.

For MAGI Medicaid, if income information received from the Federal Hub is not within reasonable compatibility, eligibility is held pending for 30 days or until the verification is provided, whichever is earlier. If at the 30-day limit no verification is received, at worker discretion, more time may be allowed. If additional time is not deemed appropriate and verification has not been provided, eligibility will be determined by the information from the Federal Hub that was received at initial application.

The following are examples of reasonable compatibility:

A. If the individual attests to income that is greater than the MAGI income limits, then he/she will be determined ineligible for MAGI Medicaid and the application will be denied, regardless of what the trusted data sources return. The individual has the opportunity to appeal this decision.

B. If self-attestation of income and that returned by the trusted data sources are both below the MAGI income limits, then self-attestation is sufficient and the application is approved based on the self-attested amount.

C. If self-attestation of income is below the MAGI income limit but the trusted data sources return information above the income limit, as long as the self-attested amount is reasonably compatible, then the self-attested amount will be taken and application approved based on this amount.

[Individuals are given the opportunity to dispute and provide satisfactory verification at any time if electronic information received will negatively impact eligibility.]

MS 3100 INCOME (1)

Income is money received from sources including, but not limited to, wages, self-employment, nonrecurring lump sums and statutory benefits, such as Unemployment Insurance Benefits (UIB) and RSDI. Modified Adjusted Gross Income (MAGI) income is based on the previous year's tax return. If an individual states that the previous year's tax return is not representative of the current year or if income has changed, the individual must provide verification of the current income to be considered in the case.

Both Federal and State data sources are used to verify income. The Federal data source is the initial source for verification and takes precedence over all other data sources. The client stated amount and the income verified by the trusted data sources must be compatible within 10 percent or the individual must provide additional verification.

For MAGI Medicaid, the individual is allowed 30 days to return any required income verification. The 30 day count starts the day the Request for Information (RFI) is generated.

[For MAGI Medicaid if the total countable income exceeds the appropriate Federal Poverty Level (FPL), Worker Portal will apply a 5 percent increase to the FPL. Income is then compared to the increased FPL for the eligibility determination. This is only used to determine initial eligibility and is not used to move an applicant to a higher level of coverage, for example from KCHIP to Medicaid.]

MS 3150 MAGI INCOME VERIFICATION (1)

[The Modified Adjusted Gross Income (MAGI) calculation is based on federal tax rules. The MAGI total is the Adjusted Gross Income (AGI) plus tax exempt interest, foreign earned income, RSDI received by adults, RSDI received by children who are considered non-filers, and RSDI received by dependents if they have a tax filing requirement.

Client stated income entered in Worker Portal should reflect an individual's current and ongoing situation. If the stated income meets reasonable compatibility it is considered "Passed" and no further verification is required. If the income does not meet reasonable compatibility it will "Fail" federal and state data matches, and verification is required.

Do not limit an individual to one particular type of verification. When verification is requested, the worker should review the various acceptable sources with an individual. All verification of income is scanned into Electronic Case Files (ECF).

Verification may come from a variety of sources including but not limited to the following:]

A. Federal Tax Forms:

1. Forms 1040, 1040A, and 1040EZ and appropriate supplemental federal forms.

2. Wages can be verified using tax forms as long as the individual states that what they earned last year, they anticipate earning this benefit year. This income can be entered as an annual amount; however, workers should ensure that the income covered the entire taxable year. If not, calculate and enter as monthly amount.

   For example, an individual indicates that the wages verified on form 1040 are only for a six month period as current employment started on 6/1/2014. Divide the total by 6, enter as a monthly amount, and document in case notes.

3. Review all entries on the tax form and ensure that the income received the previous tax year is representative of the current situation.

4. If an IRA distribution is shown on the form, inquire if the individual plans to take the distribution in the current benefit year. A written statement from the individual is acceptable verification if he/she states they do not intend to take the distribution.

5. Tax forms should not be used to verify RSDI or Unemployment benefits. These are entitled benefits and should be verified using an award letter, system inquiry, or contact with the appropriate agency.

6. Self-Employment and Farm Income can also be obtained from these forms by reviewing the appropriate entries on federal tax forms.

B. Wage Stubs:

1. [Request prior two months if representative. Verification of prior two months may include but is not limited to the following: actual pay stubs, printout from employer, or pay information obtained from the Work Number.]

2. Pay stubs should be entered according to pay date.

   For example, if a person is paid weekly, workers should enter each pay stub as a separate weekly amount.

3. When entering income from pay stubs, do not include in the gross any pre-taxed amounts such as deductions for IRA or HealthCare Spending Accounts. Workers should review pay stubs for these pre-taxed amounts and clarify any questions with the individual.

4. [Determine if all pay received in prior two months is representative of ongoing income. If it is determined that a pay stub(s) is not representative, answer “no” to “include in projections” on Income Verification screen. Document in case notes the reason(s) the check is not included in ongoing projections.]

   For example, the client states that a pay stub received is not representative as it included overtime and this is not anticipated ongoing.

C. Award Letters:

1. Current award letters can be used to verify entitled benefits such as RSDI or Unemployment Insurance Benefits (UIB).

2. Award letters can also be used to verify pensions such as VA or private pensions.

D. Written Statement:

1. Workers may use a written statement from an employer to verify ongoing income if prior wage stubs are unavailable or not representative.

   For example, an individual has been employed for several months at the same business, but states that they are going to receive a raise in pay effective with their next pay period. Because the prior two months are not representative of the ongoing situation, request an employer statement including amount, effective date, and other pertinent information.

2. Forms such as PAFS-700 may also be used in lieu of a written statement.

E. Personal Records:

1. Personal Records may be used to verify income if tax forms are not appropriate.

2. Request income AND expenses if verifying self-employment.

F. System Inquiry:

[1. Program 48, WAGE RECORDS, on KYIMS

2. BENDEX on Worker Portal

3. SDX, Supplemental Data Exchange, on Worker Portal ]

G. Collateral Contacts:

1. Person and/or Agency issuing payment;

2. Document in comments name, date, and phone number of collateral.

MS 3160 VERIFICATION OF NO INCOME (1)

[Client statement of no income is accepted for Modified Adjusted Gross Income (MAGI) Medicaid.

A. Verification of no income is not required for any member of the household, including the head of household, unless questionable.

B. For individuals whose statement of no income is accepted, select “No” from the drop down menu on Worker Portal for the question, “Is no income verification required?”

C. If the client’s statement of no income is questionable, select “Yes” from the drop down menu on Worker Portal for the question, “Is no income verification required?” and request verification. Document in case notes why verification is being requested.]

Verification can be provided by collateral contact, a signed written statement from a non-household member, or Form PAFS-702, Proof of No Income.

MS 3180 MAGI DEDUCTIONS (1)

Modified Adjusted Gross Income (MAGI) calculations allow for certain deductions from the Adjusted Gross Income (AGI). Verification of MAGI deductions is not mandatory. If an individual fails to provide the requested documentation, eligibility will be determined without the deduction.

A. Tuition and Fees;

1. The deduction is allowed only for tuition/fees for post-secondary education in an eligible institution;

2. Maximum allowable deduction is $4,000.00;

[3. The deduction is entered on Worker Portal under the person responsible for payment of the expense; and]

4. Acceptable verifications are Form 1098-T, Federal Tax Forms 1040 (Line 34), or Federal Tax Form 1040A (Line 19).

B. Educator Expenses:

1. Maximum Allowable deduction is $250.00 for a single filing status or $500.00 for a married filing joint tax return;

2. Acceptable verifications are Federal Tax Forms 1040 (Line 23) or Federal Tax Form 1040A (Line 16).

C. Student Loan Interest:

[1. Deductions should be entered on Worker Portal under the person responsible for the expense;]

2. Acceptable verification is Form 1098-E, Federal Tax Form 1040 (Line 33) or Federal Tax Form 1040A (Line 18).

D. Contributions to Health Savings Account:

[1. Deductions should be entered on Worker Portal under the person making the contribution;]

2. Acceptable verifications are check stubs under Voluntary Deductions, annual statements or Federal Tax Form 1040 (Line 25).

E. IRA Contributions:

[1. Deductions should be entered on Worker Portal under the person responsible for the contribution;]

2. Acceptable verification is Federal Tax Form 1040 (Line 32).

F. Alimony:

[1. Deduction should be entered on Worker Portal under the person making the contribution;]

2. Acceptable verifications are Federal Tax Form 1040 (Line31a) or Court Documents.

MS 3200* EXCLUDED INCOME (1)

Excluded income is income received but not considered in determining financial eligibility. The following types of income are considered as excluded income in MAGI Medicaid

A. Child Support;

B. Black Lung;

C. Worker's Compensation;

D. Veteran's Disability (VA Pension is countable);

E. K-TAP and Kinship Care payments;

F. SSI benefits and any other income of SSI beneficiaries;

G. SSI essential person's portion of the SSI payment;

H. Low Income Home Energy Assistance Program (LIHEAP) payments;

I. In-kind income;

J. Any payment made by the Division of Protection and Permanency (DPP) for child foster care, adult foster care, subsidized adoptions, or personal care assistance;

K. Home produce for household consumption;

L. Vendor payment income, payments on behalf of or for the benefit of the individual, other than the State Supplementation individual made DIRECTLY to a doctor, pharmacist, landlord, or utility company by another individual;

M. Income of a child technically excluded from MA case;

N. MAGI Medicaid child's earnings when below the limit required to file Federal Income Tax;

O. All student work-study income, education grants, and loans to any undergraduate made or insured under any program administered by the U.S. Commissioner of Education or under the Bureau of Indian Affairs student assistance programs;

P. Principal of loans, including educational loans;

Q. Highway relocation assistance;

R. Urban renewal assistance;

S. Federal disaster assistance and State disaster grants;

T. Reparation payments from the Federal Republic of Germany;

U. Experimental housing allowance program payments made under the annual contributions contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended, and HUD Section 8 payments for existing housing under Title 24, Part 882;

V. Public Law benefits and payments to:

1. Elderly persons under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended;

2. VISTA volunteers under Title I of PL 93-113 to Section 404(g);

3. Individual volunteers for supportive services or reimbursement of out-of-pocket expenses while serving as foster grandparents, senior health aides or senior companions and to persons serving in Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other programs under Titles II and III, pursuant to Section 418 of PL 93-113;

4. Indian tribe members under PL 92-524, PL 92-134, and PL 94-114 pursuant to Section 5 effective October 17, 1975 or PL 94-540;

5. Natural children of women's veterans who served in Vietnam during the Vietnam era who receive benefits based on Sec. 401 of the Veteran Benefits and Health Care Improvement Act of 2000, Public Law 106-419;

W. Consider the income not available when the parties of jointly held income are not willing to release their portion of the income or one party cannot be contacted for a release of his/her portion. Verify that litigation would be required or is pending to determine to whom an income belongs. Spot-check monthly or in the month the litigation is completed;

X. Reimbursement for:

1. Training-related expenses made by a manpower agency to recipients in institutional or work experience training;

2. Transportation, lodging and meals in performance of employment duties, if identifiable; and

3. Training-related expenses or other reimbursements by WIA to a MA child.

Y. Income excluded by terms of a trust;

Z. Small nonrecurring cash gifts, of $30 or less, but not totaling more than $30 per member of the assistance group per month. See MS 4377;

AA. Education related transportation payment and school supplies provided by a public agency or nonprofit organization;

BB. Up to 12,000 to Aleutians and $20,000 to individuals of Japanese ancestry for

payments made by the federal government to compensate for hardship experienced during World War II. All recipients of these payments are provided with written verification by the federal government;

CC. Federal tax refunds are excluded as income for 12 months from the month of receipt. This includes advance Earned Income Tax Credit (EITC) payments;

DD. All payments received from Agent Orange;

EE. Interest on burial reserves, if allowed to accrue;

FF. Any payments received from the Radiation Exposure Compensation Trust Fund;

GG. Austrian social insurance payments based, in whole or part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act;

HH. Educational grants and scholarships obtained and used, even if conditions do not preclude their use for current living costs, including payments for actual education costs made under the Montgomery GI Bill; education payments made under the Carl D. Perkins Vocational and Applied Technology Educational Act Amendments of 1990 made available for attendance costs. Attendance costs are described as:

1. Tuition and fees normally assessed for a student carrying the same academic workload as determined by the institution, and including cost for rental or purchase of any equipment, materials or supplies required of all students in the same course of study; and

2. Allowance for books, supplies, transportation, dependent care and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

II. AmeriCorps educational awards paid directly to the institution;

JJ. Payments made by Nazi Persecution Victims Eligibility Benefits Act (PL 103 286) to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required;

KK. Money paid to hemophiliacs as a part of a class action suit for Factor VIII or IX clotting agent. Additionally, these hemophiliacs must have their financial eligibility determined using SSI standards. This income is NOT excluded by SSA, so these recipients should not be SSI eligible;

LL. Money paid to individuals in the Susan Walker vs. Bayer Corporation class action suit;

MM. Family Alternatives Diversion (FAD) payments;

NN. Kentucky Works Program (KWP) supportive services and transportation

payments;

OO. Tobacco Settlement Income is excluded in the month of receipt and the month after receipt. It is considered a countable resource in the third month and thereafter; and

PP. Gifts and Inheritances.

## *MS 4000 TRANSITIONAL MEDICAL ASSISTANCE (1)

Some families receiving Medicaid (MA) in the Parent Caretaker Relative (PACA) type of assistance (TOA) may receive up to 12 months of Transitional Medical Assistance (TMA) if they have increased income which exceeds the MA Scale. The parent/caretaker relative must have received MA in the PACA TOA in 3 of the prior 6 months. The parent/caretaker relative must continue to meet technical eligibility requirements for the PACA TOA including having a dependent child in the household.

A. Families may be eligible for TMA if the parent/caretaker relative is no longer income eligible for Medicaid due to:

   1. New or increased earned income which causes household income to exceed the MA scale; or

   2. New or increased spousal support which causes household income to exceed the MA scale.

B. The following are the different TOA's for TMA:

   1. TMAE – adult in TMA household with earnings.

   2. TMCE – child in TMA household with earnings.

   3. TMAS – adult in TMA household with spousal support.

   4. TMCS – child in TMA household with spousal support.

C. TMA recipients are required to participate in managed care.

D. TMA eligibility begins the first month the parent/caretaker relative becomes ineligible for PACA.

E. When TMA is discontinued, Worker Portal will explore eligibility in other TOA's.

## *MS 4100 TMA ELIGIBILITY AND REPORTING REQUIREMENTS (1)

Transitional Medical Assistance (TMA) with earnings consists of two 6 month periods of eligibility. TMA with spousal support consists of one 4 month eligibility period. There is no income limit for TMA with earnings in the first 6 month eligibility period. TMA with spousal support has no income limit for the entire 4 month eligibility period.

A. TMA with Earnings

1. In the first 6 months of TMA receipt individuals are required to report their income in the 4th month to determine income eligibility for the second 6 months of TMA.

2. In the second 6 months of TMA receipt the countable household income must not exceed 185% of the Federal Poverty Level (FPL). In the 7th and 10th months of TMA receipt, income must be reported to determine continuing eligibility for TMA.

3. Form MA-800, Transitional Medical Assistance Report Form, is used to report income in the 4th, 7th, and 10th months.

   a. Form MA-800 is issued on the 21st day of the month prior to the report month.
   b. If form MA-800 is not received by the 10th day of the report month, the MA-801 reminder notice is issued along with another form MA-800.

B. TMA with Spousal Support

There are no reporting requirements or income limits for TMA with spousal support.

*MS 4200 TRANSITIONAL MEDICAL ASSISTANCE
GOOD CAUSE (1)

Form MA-800, Transitional Medical Assistance Report Form, is considered untimely if received after the 21st day of the report month. If form MA-800 is received after the 21st, make a good cause determination.

A. Good cause exists for returning form MA-800 untimely if one of the following reasons are met:

1. The parent/caretaker relative is out-of-town for the entire reporting period;

2. An immediate family member living in the home is institutionalized or died during the reporting period;

3. The household was the victim of a declared natural disaster, such as a flood, storm, earthquake or serious fire; or

4. The household moved and reported the move timely, but the move resulted in a delay in receiving or failing to receive the report form.

B. If good cause exists for the untimely return of form MA-800 and the case has discontinued, the case should be reinstated.

C. If form MA-800 is received untimely and good cause does not exist, Transitional Medical Assistance (TMA) will end and Worker Portal will explore eligibility in a different type of assistance (TOA).

MS 4300 [QHP AND APTC

Individuals who are not eligible for Medicaid but are looking for affordable health care coverage may enroll in a qualified health plan (QHP) through the Federally Facilitated Marketplace (FFM). In addition to enrolling in a QHP, individuals can also apply for financial assistance towards paying for a QHP on the FFM through the Advanced Premium Tax Credit (APTC) program.

A. A QHP is a commercial insurance plan offered through the FFM. These plans are offered to individuals at full premium cost or with premium assistance for qualified individuals.

B. APTC is premium payment assistance for individuals and families whose income is between 100% and 400% of the Federal Poverty Level (FPL). The assistance is in the form of a tax credit that can be applied monthly or utilized as an annual tax credit when filing a federal income tax return. An individual must be determined ineligible for Medicaid in order to qualify for APTC.

C. Individuals receiving Medicare are not eligible to purchase a QHP or receive APTC.

D. An individual may submit an application for APTC or QHP at any time during the year, but the individual can only enroll in a QHP during open enrollment and special enrollment periods.]

MS 4310* ACCOUNT TRANSFERS (1)

Beginning with the 2017 open enrollment period (November 1, 2016 – January 31, 2017) all Advanced Premium Tax Credit (APTC) and Qualified Health Plan (QHP) eligibility determinations for the 2017 coverage year will be made by the Federally Facilitated Marketplace (FFM).

However, individuals are still able to begin an application for Insurance Affordability Programs (IAPs), APTC, and/or QHP through Worker Portal, the Self Service Portal (SSP), or the FFM. Depending on the program the individual is eligible or potentially eligible for their account will be transferred to the appropriate system for eligibility to be determined.

A. Individual applies through Worker Portal or the SSP:

1. If an individual is found to be eligible for Medicaid, no account transfer to the FFM will occur;

2. If an individual is found to be ineligible for Medicaid, their information will have an account transfer to the FFM as potentially eligible for APTC and/or QHP; or

3. If an individual's Medicaid application is denied for a procedural reason (ie. not returning mandatory verification), no account transfer will occur as Medicaid eligibility has not been determined.

B. Individual applies through the FFM:

1. If an individual is approved for APTC and/or QHP, no account transfer to Worker Portal will occur.

2. If an individual is found to be potentially eligible for Medicaid, an account transfer will occur from the FFM to Worker Portal so that a Medicaid eligibility determination can be made.

a. Account transfers from the FFM will attempt to automatically run eligibility; however, there are instances in which worker intervention will be required before eligibility can be determined. When worker intervention is required, one of the following tasks will be created:

1) Incoming Application Task – Created when an incoming account transfer is missing necessary information for eligibility to be determined;

2) Report a Change or Renewal Task – Created when an individual in a Mixed Household reports a case change, or initiates an APTC/QHP renewal at the FFM;
3) Failed Member Match – Created when an individual in an account transfer has a partial or full member match with an individual already present in Worker Portal.

C. Mixed Households:

1. These are households which consist of at least one member receiving Medicaid or KCHIP and at least one member receiving APTC and/or QHP.

2. In these situations a household will have an account with, and eligibility determined by, both the FFM and DCBS.

EXAMPLE: A household consisting of a mother, father, and 10 year old daughter with an EDG size of 3 and $2500 a month income applies for Medicaid through the Worker Portal.

The daughter is approved for KCHIP and will maintain an active case on Worker Portal.

The parents are both assessed as potentially eligible for 2017 coverage year APTC/QHP and have their account transferred to the FFM for their APTC/QHP eligibility to be determined.

MS 4500 MAGI ACRONYMS (1)

This is a general glossary of commonly used acronyms associated with Modified Adjusted Gross Income (MAGI) Medicaid. Detailed definitions of the more commonly used terms can be found in MS 1050, MAGI Medicaid Definitions.

| Acronym | Definition |
|---|---|
| ACA | Affordable Care Act |
| AGI | Adjusted Gross Income |
| AIAN | American Indian/Alaskan Native |
| APTC | Advance Premium Tax Credit |
| ATIN | Adoption Taxpayer Identification Number |
| CHIP | Children's Health Insurance Program |
| CMS | Centers for Medicare & Medicaid Services |
| COLA | Cost of Living Adjustment |
| CSE | Child Support Enforcement |
| CSR | Cost Sharing Reductions |
| DAC | Disabled Adult Child |
| DHS | Department for Homeland Security |
| DMS | Department for Medicaid Services |
| E&E | Eligibility & Enrollment |
| EDG | Eligibility Determination Group |
| EIN | Employer Identification Number |
| ESI | Employer Sponsored Insurance |
| FDSH | Federal Data Services Hub |
| FPL | Federal Poverty Level |
| HIPAA | Health Insurance Portability and Accountability Act |
| HMO | Healthcare Maintenance Organization |
| KCHIP | Kentucky Children's Health Insurance Program |
| KOG | Kentucky Online Gateway |
| LPR | Lawful Permanent Resident |
| MAGI | Modified Adjusted Gross Income |
| MCI | Master Client Index |
| MEC | Minimum Essential Coverage |
| NON-MAGI | Non-Modified Adjusted Gross Income |
| PE | Presumptive Eligibility |
| PRTF | Psychiatric Residential Treatment Facility |
| PTC | Premium Tax Credit |
| QHP | Qualified Health Plan |
| QI1 | Qualified Individuals Group 1 |
| QMB | Qualified Medicare Beneficiary |
| SLMB | Specified-Low Income Medicare Beneficiaries |
| SSP | Self Service Portal |
| TDS | Trusted Data Source |
| [TMA | Transitional Medical Assistance] |
| USCIS | United States Citizenship and Immigration Services |
| VIS | Verification Information System |

## MS 5100* OVERVIEW OF KENTUCKY HEALTH (1)

The Kentucky Helping to Engage and Achieve Long Term Health (HEALTH) program is a program for MAGI Medicaid recipients which encompasses several aspects including cost sharing, community engagement, premium assistance, and a rewards program. The intent of Kentucky HEALTH is to motivate Medicaid recipients to improve their health and well-being by playing an active role in their healthcare coverage. It is designed to be similar to commercial market policies and prepare individuals to eventually transition to private health insurance.

Low-income adults, parent/caretaker relatives, children, and pregnant women categories of assistance are all part of Kentucky HEALTH; however, not all categories are subject to the requirements of Kentucky HEALTH. Individuals considered medically frail are not subject to the requirements for Kentucky HEALTH regardless of their category of assistance.

A. Individuals who receive Medicaid in low income adult, parent/caretaker relative or transitional medical assistance categories are subject to premium payments. Pregnant women are exempt from premium payments through their post-partum period. Individuals determined to be Medically Frail will have the option to pay premiums to access enhanced benefits through their My Rewards Account. Members are never required to pay more than 4% of their income through premium payments or copayments. Once the member's 4% limit is reached, the member's premium amount will be set to $1, or their copayment amount will be set to $0 for the remainder of the quarter. Individuals who fail to make their required payments will be subject to non-payment penalties, which could result in a six-month suspension.

B. All Kentucky HEALTH adults are required to participate in the Partnering to Advance Training and Health (PATH) Community Engagement activities to maintain eligibility, unless the member is exempt for a qualified reason. Members will either be required to report PATH hours unless they meet an exemption or satisfactory condition for the PATH program. Individuals are exempt from the PATH requirements if they are pregnant, a full-time student, the primary caregiver of a child or disabled tax dependent living in their home, or determined to be Medically Frail. Kentucky HEALTH members required to report PATH hours must report 20 hours a week or an average of 80 hours per month. Members who fail to complete their Community Engagement requirement are subject to suspension from managed care enrollment. Failure to clear the suspension prior to the members recertification will result in ineligibility for a new certification period.

C. The My Rewards Account allows eligible Kentucky HEALTH members access to vision and dental benefits that otherwise are not covered under the Alternative Benefit Plan (ABP). Any member participating in the premium plan will have an active My Rewards Account. Individuals who are exempt from premium payments will not have a My Rewards Account. Medically Frail individuals and Former Foster Care Youth who elect to pay premiums will have an active My Rewards Account. Pregnant Women aged 19 or older are eligible for My Rewards Account if they are do not have any penalties or suspensions at the time the report pregnancy. Children are not eligible to receive a My Rewards Account.

MS 5110* KENTUCKY HEALTH DEFINITIONS (1)

Chronic Homelessness: Occurs when an individual is living in a homeless shelter, safe haven, or a place not meant for people to live in, such as a car or out in the elements. Homelessness is chronic when the individual has been living in these conditions for 12 months or has had four 3-month periods of homelessness within 36 months.

Chronic Substance Use Disorder (SUD): A condition in which the use of alcohol or drugs has impaired an individual from social or occupational functioning.

Conditional Eligibility: Occurs when an applicant completes an application and meets all eligibility criteria, but has not yet submitted a premium payment. Applicants have no coverage during conditional eligibility.

Copay Plan: A cost sharing plan that requires members to submit payment to providers for services received.

Cost Share: This is the requirement for a member to contribute to the cost of their medical coverage through payment of premiums or copayments.

Deductible Account: A state funded account that tracks the cost of non-preventive services throughout a calendar year. The balance remaining in the deductible account could be transferred into the members My Rewards Account if eligible.

Fast Track: This is the act of selecting a Managed Care Organization (MCO) and submitting a payment at the time of application. Fast Track allows members to expedite their coverage start date to the first of the month in which the Fast Track payment is made.

My Rewards Account: An account that allows members to complete qualifying activities to earn My Rewards dollars. The dollars may be used to access enhanced benefits not covered by their benefit plan such as dental and vision services.

Premium Plan: A cost sharing plan that requires members to pay a monthly payment to their MCO to receive Medical coverage. Paying a premium payment allows members access to a My Rewards Account.

Presumptive Eligibility (PE): A temporary determination of Medicaid based on the client’s statement. PE determinations are made by qualifying entities such as hospitals and health departments.

## MS 5150* KENTUCKY HEALTH RECERTIFICATION (1)

Members subject to Kentucky HEALTH must recertify every 12 months to determine ongoing Medicaid eligibility. Certification periods begin the first of the month in which eligibility is approved, and does not include conditional eligibility periods. Members who fail to comply with recertification requirements may be subject to penalties.

A. Individuals subject to Kentucky HEALTH and receiving Medicaid in the Low Income Adult (ADLT) and Parent and Caretaker Relative (PACA) Types of Assistance (TOA) who fail to recertify must reapply for Medicaid within 90 days of the renewal discontinuance to avoid a 6-month penalty period.

   Example: Carol was receiving in the ADLT Type of Assistance (TOA) and was due to recertify in December. She was directed through the active renewal process and failed to return form EDB-087, Renewal for Medical Coverage, and was discontinued effective January 1st. She reapplied 3/23/2018 and was determined eligible for Medicaid. As she reapplied within 90 days of the renewal discontinuance, Carol is not subject to a 6-month penalty period.

   1. Individuals who reapply within the 90-day grace period are not subject to conditional eligibility.

   2. Completing a reapplication during the 90-day grace period allows the member to be placed into the payment plan they were in prior to discontinuance if found eligible.

B. Failure to reapply within the 90-day grace period results in an untimely recertification penalty. Individuals serving an untimely recertification penalty are locked out of receiving benefits for 6-months or until the member completes a re-entry course to lift the penalty.

   1. Only members who were eligible to receive Kentucky HEALTH Medicaid benefits in the ADLT and PACA TOAs in the month of recertification are subject to the untimely recertification penalty.

   2. Children and individuals who have been determined Medically Frail at the time of recertification are exempt from the untimely recertification penalty.

      Note: the certification end date will be extended to the end of the deemed eligibility period for deemed eligible newborns and pregnant women who fail to initiate or complete recertification.

   3. Individuals reapplying while serving a recertification penalty are required to clear the penalty by completing a re-entry course in addition to completing conditional eligibility criteria to be approved. Failure to clear the penalty by the end of the conditional eligibility period will result in ineligibility.

   4. Upon reapplication, members who report pregnancy, or are determined to be Medically Frail will have the recertification penalty lifted.

Note: Women reporting pregnancy while reapplying during a recertification penalty are eligible for retroactive coverage.

C. Members in a suspension period at the time of recertification or at the recertification end date are required to clear the suspension as a condition of recertification completion. Failure to clear the suspension prior to the recertification end date results in the discontinuance of ongoing benefits. Members who discontinue for failure to clear a suspension do not receive an untimely recertification penalty, and do not receive a 90-day grace period.

1. A non-payment penalty stays with an individual regardless of changes to their eligibility, unless the member lifts the penalty or the penalty expires. Therefore, non-payment penalties for members with income below 100% of the Federal Poverty Level (FPL) are applied to the member's new certification period if not cleared prior to recertification.

2. Individuals serving a non-payment suspension (income over 100% of the FPL) are discontinued at recertification if the suspension is not lifted. Non-payment suspensions will carry forward into the new certification period. Individuals who reapply without clearing their non-payment suspension penalty are made conditionally eligible and are required to clear their suspension to gain approved eligibility.

3. Individuals reapplying within one month of being discontinued, either for failure to recertify or failure to clear a PATH suspension will have their PATH suspension applied to their new certification period.

    a. Upon reapplication these individuals will be conditionally eligible, are required to clear the PATH suspension, and complete conditional eligibility criteria to gain approved eligibility.

    b. Individuals reapplying after PATH suspension applied to their new certification period. However, they will be subject to conditional eligibility requirements.

    c. Upon reapplication if an individual reports a PATH exemption or reports a change that would meet their PATH requirement, the PATH penalty is end-dated effective the month prior to the report of the exemption.

D. Individuals serving a recertification penalty may submit a good cause request. An approved Good Cause request lifts the recertification penalty and prevents the requirement for completing re-entry criteria. Good cause requests can be submitted at reapplication via the Self-Service Portal (SSP), or entered into Worker Portal on the "Good Cause" screen. Verification is required to approve a good cause request. Individuals approved for Good Cause are required to complete an application and are subject to conditional eligibility.

Allow Good Cause for failure to recertify if one of the following reasons are met:

1. An immediate family member living in the home is institutionalized or died during the recertification period;

2. The household was the victim of a declared natural disaster, such as a flood, storm, earthquake, or serious fire;

3. The household moved and reported the move timely, but the move resulted in a delay in receiving or failing to receive form EDB-087, EDB-088, Renewal Reminder Form for Medical Coverage, or the Request for Information (RFI);

4. The head of household was hospitalized, or otherwise incapacitated for the entire recertification period;

5. The household was victim to domestic violence during the recertification period;

6. The household obtained or lost private health insurance during the recertification period; or

7. The household was evicted from their home or became homeless during the recertification period.

MS 5400* MEDICALLY FRAIL (1)

Kentucky HEALTH recognizes individuals with certain health related issues may be Medically Frail and unable to comply with all of the Kentucky HEALTH requirements. Individuals who are determined Medically Frail are not required to complete PATH community engagement hours and have the option to pay premium payments. A Medically Frail determination can be made through multiple routes; however, the Managed Care Organizations (MCO) will be responsible for making the determination for most individuals.

A. Individuals may be determined as Medically Frail through the following methods:

1. Members who are identified through state interfaces, including individuals receiving RSDI due to disability.

2. Members can self-attest in Worker Portal or on benefind Self-Service Portal (SSP) to chronic homelessness and/or difficulties with Activities of Daily Living (ADL) to be immediately deemed as Medically Frail for six months.

   a. A Medically Frail determination due to self-attestation of chronic homelessness or difficulties with ADL is limited to one immediate determination in a 5-year period.

   b. Once deemed Medically Frail due to self-attestation the member's Managed Care Organization (MCO) will attempt to verify, prior to the end of the 6 month determination, if the member is eligible to be determined Medically Frail ongoing.

   c. If the MCO determines the member is Medically Frail they will extend their Medically Frail record in Worker Portal for 12 months.

   d. If the MCO determines the member is not Medically Frail, the member will be notified by the MCO and will be provided appeal rights.

3. Individuals who state they are in poor health or have health issues other than chronic homelessness or problems with ADL, must contact their MCO to initiate a Medically Frail determination.

B. Members who are determined to be Medically Frail will receive State Plan benefits. Medically Frail members can either be in the No Cost Share or Premium plans. Medically Frail members will not be placed into the Copayment plan.

1. Medically Frail members have the option to pay premiums in order to receive access to their My Rewards Account. These individuals will be placed on the Premium plan and will be invoiced by their MCO monthly.

2. Medically Frail members who fail to submit ongoing premium payments are not subject to suspension from managed care enrollment. They are subject to a non-payment penalty which will only result in a suspension of their My Rewards Account.

3. Medically Frail members who wish to lift the penalty on their My Rewards Account must pay a premium payment and take a re-entry course.

C. Individuals who are determined to be Medically Frail upon application are not subject to Conditional Eligibility, and are fully approved effective the first day of the application month.

D. Individuals who are determined to be Medically Frail during their certification period will be transitioned to their new benefit plan effective the first day of the following month.

E. Members who are determined to be Medically Frail are not subject to Kentucky HEALTH suspensions.

1. Individuals who were previously suspended due to non-compliance with the PATH program will have their suspension lifted effective the first day of the Medically Frail determination month.

2. Individuals who were previously suspended due to non-payment will have their suspension lifted effective the first day of the month of the Medically Frail determination.

   Note: A Medically Frail determination will not lift a non-payment penalty. The member will be required to pay a premium payment and complete a re-entry course to clear the non-payment penalty and access their My Rewards Account.

3. Medically Frail members who fail to recertify timely will not be subject to the recertification penalty. Individuals determined to be Medically Frail while in an active recertification penalty will have the penalty lifted effective the first day of the month the determination is made.

4. Medically Frail members who voluntarily withdraw their Medicaid are not subject to the Voluntary Withdrawal penalty. Individuals serving a Voluntary Withdrawal penalty who are determined Medically Frail upon reapplication will have the penalty lifted when determination is made.

E. When a Medically Frail determination ends, members are transitioned to the payment variation of the appropriate plan effective the first day of the following month. The payment variation the member is enrolled with is dependent on the plan variation the member was receiving while Medially Frail. Members will receive notices informing them of their change in Kentucky HEALTH requirements.

1. Members who were making premium payments while Medically Frail will remain in the Premium Plan.

2. Members who were not making premium payments while Medically Frail will transition to the Copay Plan and will be allowed 60 days to pay the premium.

EXAMPLE: Carla is receiving Kentucky HEALTH benefits as an ADLT and has been determined to be Medically Frail. She is currently enrolled on the No Cost Share State Plan. Carla’s Medically Frail Determination ends on 1/30/2019. Effective

2/1/2019 Carla will be moved to the Alternative Benefits Plan and will be enrolled in the Copayment plan. Carla will be given 60 days to submit a premium payment.

Note: If Carla had been enrolled in the premium plan while Medically Frail she would transition to the Premium ABP.

MS 5500* MY REWARDS ACCOUNT (1)

The My Rewards Account (MRA) gives Kentucky HEALTH members receiving Medicaid in the Alternative Benefit Plan (ABP) the opportunity to access vision and dental benefits. Members can accrue My Rewards dollars by completing qualifying activities. Medicaid dental and vision providers are able to view the account balance and reserve dollars to pay for services approved by Medicaid. My Rewards dollars cannot be used as cash, and may not be used to pay for anything other than services approved by Medicaid. A member who has received coverage through commercial insurance for at least 18 months, and did not receive Medicaid during that same time, can request a payout from their MRA. The payout can be ½ of the remaining MRA balance up to $500.

A. The following members are eligible to receive a My Rewards account:

1. Individuals receiving in the ADLT, PACA, and TMA Types of Assistance;

2. Members determined as Medically Frail and Former Foster Care youth up to age 26; and

3. Pregnant Women who are 19 or older

Note: Children will not be eligible for a My Rewards account.

B. My Rewards accounts have four statuses: Active, Suspended, Inactive and Closed. The account status determines the individual's ability to accrue My Rewards dollars and use those dollars to pay for dental and vision services. Once an account becomes Active, it remains with the member through eligibility changes until the status is Closed.

1. When the account is in "Active" status, a member can accrue and redeem My Rewards dollars. A member's account will have an active status if he/she is enrolled in the Premium Plan. In addition, the MRA for a pregnant woman who had no suspensions or penalties prior to pregnancy will remain active.

2. The account status will be "Suspended" when an individual is in a penalty period or enrollment is suspended. The account remains suspended until the penalty and/or suspension is lifted. Suspended My Rewards accounts prevent the member from accruing or redeeming My Rewards dollars.

Note: Accrual activities, such as receiving preventive services, that are completed while the account is in suspended status will be credited to the members account if the account status changes to active within 60 days of the accrual activity completion.

3. The account status will be "Inactive" during conditional eligibility periods, when a member no longer receives Kentucky HEALTH, or when Medicaid is discontinued. Inactive accounts will not accrue My Rewards dollars and dollars remaining in an inactive account cannot be used. When an individual transitions into Kentucky HEALTH, the account will remain "Inactive" until a premium payment is submitted.

4. The account status will be “Closed” when a member has not received Kentucky HEALTH for 5 years, or when the member completes an account payout request.

C. My Rewards Accounts are subject to deductions as a result of non-compliance with Kentucky HEALTH requirements, or for misuse of the Emergency Room. The MRA can have a negative balance due to deductions. The following actions will result in a deduction from the member’s account:

1. Receiving a non-payment penalty will result in a $25 deduction for each individual subject to premiums.

2. Receiving a voluntary withdrawal penalty will result in a $25 deduction only for the head of household if their My Rewards Account is active at the time the household’s Medicaid is withdrawn.

3. If the Managed Care Organization (MCO) determines an individual improperly used emergency services, $20 is deducted for the first unapproved visit and the deduction amount increases for each subsequent visit that is not approved. Individuals may avoid this deduction by contacting their MCO’s nurse hotline no more than 24 hours prior to an ER visit. These deductions are only applied if the members My Rewards account status is Active.

D. Refer members who have questions about vision and dental services covered by the My Rewards Account to their MCO.

E. Members may view their MRA account balances and account transactions by accessing their account on the benefind Self-Service Portal (SSP) or by visiting Citizen Connect at https://citizenconnect.ky.gov. They can also access a list of qualifying activities to earn My Rewards dollars by visiting Citizen Connect.

MS 5600* DEDUCTIBLE ACCOUNT (1)

The Deductible Account is a virtual account intended to educate members on the cost of health care and familiarize them with commercial health insurance. Medicaid pays the deductible and members incur no actual expenses. The member's Managed Care Organization (MCO) manages and tracks the account. Summary statements will be sent to the member monthly by their MCO to inform the member of any transactions and the balance. The account balance can also be found on the Worker Portal Individual Summary screen. Refer members with questions about their Deductible Account to their MCO.

A. Individuals receiving Kentucky HEALTH in the ADLT, PACA, TMAE, TMAS and FFCC Types of Assistance (TOA) have a Deductible Account and will receive a monthly summary. This includes individuals determined to be Medically Frail.

B. The following Kentucky HEALTH members do not have a deductible account and will not receive a summary:

   1. Children age 18 or under.

   2. Pregnant women, including the post-partum period.

      a. The deductible account is frozen when an active member reports pregnancy.

      b. Women who are pregnant at application, member add, or at the beginning of the calendar year will not receive a deductible account until the end of their post-partum period.

C. The cost of preventative services will not be subtracted from the Deductible Account. The account only tracks and subtracts the costs for non-preventative services from the Deductible Account.

D. If a member changes MCOs, their Deductible Account balance transfers to the new MCO. The Deductible Account balance does not reset due to a MCO change.

E. At the end of a calendar year, up to 50% of the remaining balance in the Deductible Account will be transferred to the member's My Rewards Account.

   1. 90 days after the end of the calendar year, 50% of the remaining balance to the member's My Rewards account.

   2. Members who were not eligible to receive a deductible account for the full benefit year for any reason, such as a pregnant woman, will have their deductible balance prorated based on months of enrollment. Only 50% of the prorated balance is transferred into their My Rewards account.

   3. The balance can be applied to a suspended or active My Rewards account. If the account is suspended, the member has 60 days to clear the suspension and reactivate the My Rewards account or the amount transferred will be removed from the account.

MS 5710* VOLUNTARY WITHDRAWAL PENALTY (1)

Individuals who voluntarily withdraw from Kentucky HEALTH may be subject to a 6-month penalty. The Voluntary withdraw penalty is designed to prevent members from leaving Kentucky HEALTH in order to avoid receiving or clearing a penalty.

A. A voluntary withdrawal penalty is effective the first of the month in which a member voluntarily withdraws their household from receiving Medicaid. A voluntary withdrawal penalty is not applied when individuals report a change in circumstances resulting in discontinuance, such as an increase in income or moving out of state.

B. Members receiving in the following Types of Assistance (TOA) are subject to a voluntary withdraw penalty:

1. Low Income Adults age 19-64 (ADLT);

2. Parent and Caretaker Relatives (PACA);

3. TMA- Increased Earned Income (TMAE);

4. TMA- Increased Spousal Support (TMAS);

C. The following members are exempt from receiving a voluntary withdraw penalty:

1. Individuals determined to be Medically Frail;

2. Pregnant Women;

3. Former Foster Youth up to age 26;

4. Children;

5. Members with an active non-payment penalty. Members with an active non-payment penalty will not receive the voluntary withdraw penalty, but instead will be required to clear their non-payment penalty if they reapply prior to the end of their penalty period.

D. A 6-month voluntary withdrawal penalty is applied to the head of household only.

1. A $25 deduction is made to the head of household's My Rewards Account;

2. If the member wishes to reapply during the 6-month penalty, the head of household is required to complete a re-entry course in addition to conditional eligibility criteria.

3. Other household members will not be effected by the 6-month penalty.

E. Individuals reapplying within the 6-month penalty period may provide a good cause reason as to why they withdrew their case. Good cause is met if one of the following reasons are reported and verified:

1. Individual moved out of state;

2. Began receiving coverage under Employer Sponsored Insurance (ESI);

3. Individual had an increase in income that put their FPL above the Medicaid limit; or

4. A death of a household member, or change in household composition would have made the household ineligible for Medicaid.

MS 5800* PRESUMPTIVE ELIGIBILITY (1)

Presumptive Eligibility (PE) is time limited Medicaid which is issued when qualifying healthcare providers enroll individuals without verification. Individuals are presumed to be eligible based on their statement. The time-limited period ends the last day of the month after the month PE is issued. Individuals may only receive PE once in a twelve month period or once per pregnancy.

Kentucky HEALTH members who have an active penalty are not eligible for PE. In order for PE members to transition to Kentucky HEALTH without a period of conditional eligibility, they must submit a Medicaid application prior to the end of their PE period. PE eligibility will be extended until the Medicaid eligibility determination is made for individuals who submit a Medicaid application while still in their PE period.

A. Certain PE members are subject to Kentucky HEALTH benefit plans and copayment requirements.

   1. Women receiving PE as a Pregnant Woman (PEPR) are assigned the State Plan, and have no Cost Share requirement.

   2. Adult members receiving PE in the PEAD Type of Assistance (TOA) are assigned the Alternative Benefit Plan (ABP) with a copayment requirement.

   3. Parent and Caretaker Relatives receiving PE under the PEPC TOA are assigned the State Plan, with a copayment requirement.

B. While receiving PE:

   1. Individuals are not subject to premium payments or PATH requirements.

   2. Months will not count in a members Cost Sharing or PATH clock.

   3. Individuals have no access to a My Rewards account.

C. PE individuals who submit a Medicaid application prior to the end of their PE period:

   1. Will not have the option to Fast Track. The Fast Track option will be available to other individuals in the household applying for Medicaid.

   2. May change their MCO prior to submitting a premium payment.

   3. Are transitioned to the appropriate benefit plan effective the first day of the month in which the application is approved. Members will transition to the copayment variation of the appropriate plan. They will have 60 days from the invoice date to submit a premium payment to their selected MCO. Members will pay a copay for any services received before making a premium payment. If a premium payment is not submitted within 60 days of the invoice date, the member may be subject to a non-payment penalty.